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ABSTRACT

A study examined the preparation of sick children's nurses to work in communities in the United Kingdom. Data were collected from the following: literature review; mail survey of the 43 colleges of nursing currently conducting the United Kingdom's Child Branch program for children's nursing (response rate, 81%); 18 focus group interviews with a total of 13 tutors, 43 students, and 15 pediatric community nurses at 4 colleges; and interviews of 13 parents of children with various health conditions regarding their perceived needs for children's nursing services. The community experiences of students preparing for employment as sick children's nurses were found to vary widely in length, nature, and quality. The study findings were used to develop a preferred model for preparing nurses to care for children in the community. Among the model's components were the following: a comprehensive community experience lasting at least 12 weeks and including lists of minimum learning experiences and outcomes; mentorship by a recognized pediatric nurse; a strong children's nursing focus; and a period of rostered community practice that includes competency assessments. (Eighteen tables, and a 62-item bibliography are included. Appended are the study consent form, questionnaire, and cover letters. Contains 113 references.) (MN)

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The Preparation of Sick Children's Nurses to Work in the Community (P2000 Evaluation)

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PREFACE

THE PREPARATION OF SICK CHILDREN'S NURSES TO WORK IN THE COMMUNITY (PROJECT 2000 EVALUATION)

The Board is pleased to publish this Final Report which provides valuable information relating to the preparation of sick children's nurses undertaking the Child Branch programmes within the pre-registration diploma in higher education. The evaluation focused specifically on community care provision for sick children and the learning opportunities offered to students.

Through a variety of means including validation, monitoring and evaluation, the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension for the development of policy. The findings and recommendations from all the research commissioned by the Board will be considered with a view to confirming or developing the Board's educational policies.

The findings and recommendations in this Final Report will be of particular interest to managers, practitioners and teachers involved in the preparation of sick children's nurses.

In response to the findings and recommendations in this Report the Board will review its regulations and guidelines relating to preparation of Child Branch students in the community.

An Evaluation of the Initial Preparation of Nurses to Care for Children in the Community in the Context of Services Needed and Provided (Project 2000 Evaluation) - A one year project commissioned by the English National Board for Nursing, Midwifery and Health Visiting.

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INTRODUCTION

The recent announcement by Virginia Bottomley, Secretary of State for Health, that the Regional Health Authorities are to be merged and then dissolved is the latest in a series of waves to hit the NHS over the last ten years. It is undoubtedly fair to say that the NHS is undergoing a programme of reforms more fundamental than any experienced since its inception. In plotting the route taken by the health service reforms to date, the milestones are many and varied.

From the NHS Management Inquiry of 1983 to the enactment of the NHS and Community Care Bill in 1990 a series of changes have been set up with profound affects on the organization and management of primary and secondary health care services.

It is extremely difficult to make any summary statement about the nature of these continuing changes, and whatever the merits and demerits of these reforms, predicting the likely effects on particular occupational groups - who wins and who loses - is hazardous. Notwithstanding the suggestion by some commentators that the reforms represent the greatest challenge to the dominance of the medical profession since its inception, there is nothing to indicate that the medical profession is about to relinquish its position of influence within the health care system (Hunter 1994). However, the growing tendency, in Britain and elsewhere in the western world, to discuss health care in

the context of fiscal constraint, financial accountability, consumer choice, and managed competition, clearly stands at odds with ideas of clinical autonomy.

For the profession of nursing, whose struggles against the dominance of medicine have been numerous (Dingwall et al 1988), there is little in the health reforms to suggest that nurses are going to benefit at the expense of doctors. However, in spite of the fact that the recommendations of Cumberlege (Department of Health and Social Security 1986) have been buried by the rubble left by subsequent reforms, the process of reform has opened up spaces within which nurse practitioner roles in the community can be enhanced (Witz 1994). For example, the concept of case management and assessment in the community care White Paper corresponds closely to the roles and tasks of the district nurse; and the emphasis on health needs assessment as the basis for commissioning services, and the stress on health promotion in the consultative document, The Health of the Nation (Department of Health 1991), clearly map onto the historic role of the health visitor. Whether these roles will be developed by way of outreach from hospital settings or within community units remains to be seen.

It is against this background of rapid change in the health services, and the general opening up of debate on the nature of health and the future of health services (Popay and Williams 1994), that this particular study stands. It is, first and foremost, a study of the preparation Project 2000 nurses

currently receive for caring for sick, as opposed to healthy, children in the community. However, the study also examines parents' perceptions of their own needs and those of their children alongside the current policies and activities of schools of nursing. In using data collected by a number of different methods from a range of sources, we feel that the results of this study have something new to say, and we hope that our report will make a contribution to a redefinition of the nurse's role for the 1990s and beyond.

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LITERATURE REVIEW

The preparation of children's nurses is taking place against a background of rapid change in the structure of paediatric care in the United Kingdom both in general terms and in relation to changes in the National Health Service. There is a general move towards increased community care for sick children, but this is within the context of uneven development of community nursing services for sick children. This change has led to a situation where the traditional, hospital based apprenticeship style preparation for nursing practice is now seen as unsatisfactory if nurses are to be educated to meet the changing needs of the community in general and children in particular.

The salient issues relating to this study which will be considered in the literature are:-

a) The background to the move towards community care for sick children.

b) The qualities of the community or home health care nurse who can provide the kind of nursing care and management that child patients and clients require at present and in the future.

c) The changes taking place in the preparation of nurses for practice

d) The role of the health visitor in nurse education.

e) The identification of the perceived needs of children and their families.

f) The kinds of services and training that are currently being provided to meet the needs of child patients and

clients and their families.

g) The possible political forces that will impact on nurse education.

Background to the move from hospital to community care for sick children

With the advent of high technology interventions and the present policy of cost containment, acutely and chronically ill children have been and will continue to be discharged into the community. It is essential that comprehensive, quality paediatric home care programmes are developed to provide a nurturing environment in which the special health, developmental and psychosocial needs of the child are met simultaneously with the family's need for technical assistance, role modelling, and psychosocial support. Ray and Ritchie (1993) state that nurses who care for chronically ill children and their families have witnessed a rapid increase in the occurrence and complexity of care that such children receive at home.

The average length of stay for a child in hospital is now 1.9 days (Atwell and Gow 1985). Nevertheless, the total number of admissions appears to have increased and children with severe long term illnesses are being admitted for frequent short intervals rather than the extended periods that were previously the case (Spencer and Lewis 1991). Although time spent in hospital has reduced there was genuine concern that the sum total of repeated short admissions was no less than the previous longer admissions. A study in Oxford by Henderson and Griffith 1990 to

1991 concluded that:

> " ... despite increases in admission rates and multiple admissions per child, the total time spent in hospital by children has declined."

They further conclude that possible further reductions in hospital stay for children could be achieved by improving community support in child health. According to Brun (1992) the number of day case admissions and children attending for out-patient appointments has

> "dramatically increased and paediatric community nursing services are rapidly expanding to care for the number of children nursed in the community".

The concept of home nursing care for the child has been the subject of much discussion for well over quarter of a century. In 1959 the Platt Report recommended that:

> "Children should only be admitted to hospital if the care they require could not be equally well provided in the home." (Platt Report 1959)

Progress was painstakingly slow initially, but appears to be gathering momentum as the possible impact of economic, social, psychological and logistical advantages of nursing the sick child in his or her own environment become apparent. Atwell and Gow (1985) highlight the numerical significance of the 50 to 60 percent of children under the age of 5 who are admitted for general surgical operations. They cite possible reduction of hospital beds, cost effectiveness of treatment, early discharge from hospital and reduction of the risks of cross infection as some of the possible advantages of increased emphasis on community care.

The Court report - Fit For The Future (1976) recommended that an integrated child health service be established and that there should be a

> " ... group of nurses who would combine a preventive and curative nursing responsibility for children and advisory responsibility in respect of their parents and who would work in close professional association with GPs, paediatricians and hospital paediatric nursing staff"

Hall and Prendergast (1990) in a discussion of the advantages of an integrated child health service cite Baroness Hooper's 1989 speech in which she states:-

> " One of the key features of high quality children's care is the integration of hospital and community services, to secure continuity through child health surveillance and necessary hospital admission and discharge back to the community".

Hall and Prendergast in a discussion of what they perceive as the obvious advantages in providing care for children in their own homes forward a particularly strong case for home care for children with ongoing health problems such as cystic fibrosis. They also see an integrated service "as an essential adjunct to day surgery".

Whyte (1992) following a study of children with cystic fibrosis suggested that a " logical extension" of the paediatric nursing role is family nursing. She feels that this concept has

> " particular relevance now that ill children are whenever possible cared for at home rather than in hospital".

She further states that definitions of family should take into account the " patterns of family grouping seen in Western society today". On the contrary Anderson and Elfert (1989) found that with regard to children with chronic illness, there was no such

thing as family nursing. The word family is usually subsumed in the term mother. Furthermore, the mother's

> "needs as a woman become overshadowed by the needs of her child -she gives up her life for her child"

Anderson and Elfert consider the implications of mothers "not displaying competence" in relation to the care of their sick child which they see as having "serious consequences" for both the mother and the child. Anderson and Elfert suggest that the inherent threat is that if the mother is judged as incompetent and therefore unfit the state can intervene and remove the child from the home. They argue that

> "women reinforce this idea that the woman is caretaker and in fact depend on it to get the job of caretaking done in the home. They trade upon this notion to promote the concept of 'homecare' management and the transfer of part of the economic costs of caring from the state to the family."

Whyte (1992) argues that there are two other concepts that must be recognised and distinguished from each other, the first is

> " the child as the focus of nursing accepting the importance of the family context and viewing the whole family as the unit of care".

The second concept which is partnership with parents in the home care and management of children with chronic illness, may not be as straightforward as it would first appear. Whyte (1992) illustrates that what may be the case is simply

> " teaching the parents how to care for their sick child, in preparation for discharge home"

Thus suggesting that what is described as a partnership is simply the provision of the relevant information to empower parents to carry out care themselves. According to Whyte the skills required should also be recognised and there should be

> "appropriate preparation of practitioners if health services are to respond to changes in society and within

their own practice".

From Whyte's work it could be construed that if the emphasis for health care continues to shift from hospital to home, then more time and resources should be spent by nurses on developing the skills to relate to the child within the context of the family as a system.

However it is interesting to note that in a study done by Ray and Ritchie (1993) parents reported that

> "Once they became competent in caring for their children's health, professionals did not demonstrate respect and appreciation for parents' central role and understanding of their child's condition".

Parents were frustrated by what has been described as the "system's lack of acknowledgement of their expertise or their time." Ray and Ritchie (1993) found that parents were comforted when they knew that professional help was available either from an identified person or by telephone, if this was needed.

Home care must be evaluated in the light of its intended objectives. If there is a commitment to comprehensive and effective health services as well as to cost savings then home care must be more cost-effective as well, taking into account that cost-effectiveness entails the provision of high quality services to the most people at the most reasonable price (Hunsberger, Anderson and Foster 1989). While home care often results in substantial savings to health care institutions it may not be cheaper for the family., Indeed, the cost may not be only in financial terms, though it is an important variable to be taken into account. Considerations such as whether one parent

must relinquish gainful employment to stay at home and care for the child must be taken into account and even if one parent is available to provide care, there is the added physical and emotional burden of continuous care for an ill child often in tandem with looking after other children who have different needs.

The Audit Commission (1993) reported that home care nursing could reduce hospital stay and admission to hospital in some cases. It stated that there is a

> "need for more RSCNs who can provide secondary care at home".

From a study being done on behalf of the Audit Commission, of 48 families surveyed the consensus of opinion was that home care nurses could provide an invaluable service to parents, children and health services.

The care delivered will be greatly influenced by the reason for home care. Home care may be for either acute or ongoing (chronic) health problems.

Home care for acute health problems

This refers to care that is needed for only a short time. This type of care for example may be appropriate for a child who requires one or two follow-up visits after day case surgery or a single visit for removal of stitches (Whiting 1992).

Home care for ongoing (chronic) health problems.

This type of care may be short term or long term. Short term care is usually necessary when the child develops an acute exacerbation of a chronic problem but short term care may also be used to refer to the period of adjustment from hospital based management to family based care.(Foster, Hunsberger and Anderson 1989). An example of this is the infant who is oxygen dependent when discharged from hospital. The family will need short term care to help them to understand and cope with oxygen administration at home. The home visiting will reduce as soon as the family can manage the child at home with occasional visits from the nurse and regular visits to the hospital.

Long term care for children with ongoing health problems means that the family will need continuing support to maintain the care at home. Examples of this are children with multiple handicaps or tracheostomies. This is usually the only alternative to long term hospitalisation and there are advantages for the child to remain within the home environment.

<u>The qualities of a community nurse or home health care nurse</u>

Giving care in the community has ostensibly very few similarities to nursing in the hospital setting. Bysshe (1990) argues that while there are some shared skills the essential attribute of the community nurse is to act as an

> "independent and autonomous practitioner with minimal support in complex and constantly changing situations".

Bysshe also highlights that decision-making skills and the ability to give safe and effective care in "less than ideal environments" are also paramount. It could be argued that these

are skills that develop through trial and error and experience rather than being taught specifically. It is apparent that health visiting and school nursing are primarily concerned with health promotion with the well population and if the Project 2000 practitioner is to be equipped to look after patients and clients who are sick or well, models other than individual placements with health visitors and school nurses should be utilised.

Successful home care nurses tend to share certain qualities such as a holistic approach and a liking for flexibility and autonomy in their work settings (Mundinger 1983, Stuart Siddall 1984). She or he is able to adapt teaching strategies to the full spectrum of physical and emotional problems (climates) that she or he may encounter. The nurse should be able to communicate an acceptance of different lifestyles and make adjustments accordingly. Cherryholmes (1986) states that the home care nurse

> "enjoys problem solving and has the ability to help the client identify the need for change and work through the change process."

The children's nurse working in the home situation should be aware that she or he is assisting a family with the implementation of a care plan. She or he must accept that the family carries a lot of the responsibility for implementation of that care with the assistance and support of the nurse, the physician and sometimes other health professionals. The home care nurse needs to spend time with the family clarifying the problems, outcomes and strategies.

There are three central questions to ask about the kind of nurse who is required to care for sick children in the community, these are -

1. What are the distinguishing features of the paediatric home health care nurse?
2. What are her or his educational and training needs?
3. What preparation has there been to date for this role?

There is a considerable body of relevant literature emerging from the United States of America although this information should be viewed within the context of the differences between the American and British health care systems.Cherryholmes (1986) defines the home health care nurse as

> "a higher level generalist who has to be able to recognise problems and trust her own judgement and clinical skills."

Furthermore, Cherryholmes suggests that a sound knowledge of normal child development and behaviour is essential in order for the nurse to make independent judgements and assessments when operating without the safety net of having colleagues with whom to collaborate in challenging situations while practising independently.

It has been argued that the home health care nurse's preparation should include hospital experience with patients of the same type as those she or he will encounter in the home (Foster, Hunsberger and Anderson 1989). They also suggest that the home health care nurse must be competent and confident in skills such as physical assessment and management of technical devices and equipment.

The practitioner who has so far been described appears to need not merely the skills to work in the community but also advanced skills in caring for children with a wide range of illnesses. Langlands (1990) asserts that the nursing profession in general, and paediatric nurses in particular, must:

> "put their case for adequate education and training beyond initial registration if standards of care for sick children and their families are to be promoted."

This view was confirmed by a working group of the English National Board and District Nursing Joint Committee members (cited in Langlands 1990) which endorsed that sick children need to receive the specialist care of a Registered Sick Children's Nurse with an additional qualification in community care.

There are two central arguments in the literature previously considered. The first is that there is a need for children's nurses who should be able to provide care for all sick children being nursed in the community, the second that this nurse will be expected to deliver specialised care that should be underpinned by post-registration education and training.

Existing Preparation for working in the community

In principle the United Kingdom Central Council (U.K.C.C.) is committed to the ethos of specialist preparation for specialist practice in the community (Registrars letter 10/1992, Proposals for the Future of Community Education and Practice). There are plans to use the term "Community Health Care Nurse" to describe a registered nurse who has completed a specific post registration

preparation in order to provide specialist nursing care in the community. The U.K.C.C. has clearly stated that this does not refer to a generic nursing course but one which will consist of a common core which will be completed by all practitioners seeking a community health care nursing qualification. This will be followed by specialist modules of theory and practice and will give accreditation for prior learning. There are, in fact proposals for changes in the education and training of all community nurses. Nevertheless, Lindsay (1993) finds it remarkable that child care nursing is the only branch of nursing that has no "nationally implemented community service". He further states that

> "The requirements and guidelines for Project 2000 curriculum development fail to give any clear indication of a model of community based children's nursing to be followed when designing or implementing a branch programme"

Lindsay's discussion is based on a small scale study conducted in 1992 and he poses several pertinent questions. For example:

- What type of community children's nursing service should we be developing?
- What role should a specialist children's nurse be fulfilling in such a service?
- Whether or not the Project 2000 child care nurse has been adequately prepared to fulfil this role.

From Lindsay's research it emerged that two facets of the role of paediatric community nurse were perceived. The first was the notion of the nurse providing support for the health visitor during the period immediately after qualification when she or he needs to work under supervision. The second aspect was undertaking the role of "specialist outreach nurse" operating from either a hospital or community base.

The inadequacy of the nursing provision for caring for children in the community was identified by Glucksman et al. (1986) who found that 25 per cent of nurses attached to General Practitioner practices have very little training in the care of sick children and do not visit schools or see children with handicaps. He discusses the overlap between the work of existing Health Visitors and community paediatric nursing services. Dryden (1990) argued that current district nurse training shows a bias towards adult needs. However, new guidelines have been introduced emphasising a child orientated focus for course work and practice supervision for Registered Sick Children's Nurses (R.S.C.N.'s). There are a number of schemes in England involving paediatric community nurses who are either R.S.C.N.'s only, or R.S.C.N.'s with a district nursing qualification. In 1988 there were fifty two paediatric community schemes in England handling a general paediatric caseload (Whiting, 1989). Furthermore, the Department of Health's (1990) strategy for nursing document endorsed the ethic that post registration training is critical for the provision of continuing care in the community. This is also within the context of demographic changes with more young people surviving disabilities, resulting in an increased need for ongoing expert health advice and support.

The Royal College of Nursing's Paediatric Community Nursing Forum (1991) outlined the groups of children which are cared for in the community. These include those with/in

- traction
- a variety of central venous lines who may be receiving chemotherapy, blood transfusions; complex intravenous

antibiotic schedules, analgesia, and total parenteral nutrition

- gastrostomies
- tracheostomies
- advanced stages of chronic or terminal illness
- continuous oxygen therapy, possibly being ventilated and requiring constant monitoring".

The article also makes reference to the reticence of the United Kingdom Central Council (UKCC) in acknowledging explicitly "the sick child in our communities".

Hunter and Judge, (1988) indicated that a multiplicity of community provision would be valued especially by the consumer. The Department of Health (1992) explicitly promises clients that their continuing health or social care needs identified upon discharge from hospital will be met by community nursing services and local authority social services departments.

There is some relevant literature on the actual establishment of need and much of the literature available particularly in the American context relates to the financial ramifications of care and the cost of meeting identified needs. The perspectives that have been offered in many cases are those of the professional. It could be argued, therefore, that the content of a paediatric community team's work has not been fully articulated in relation to the perceived needs of the children and their families. There is a suggestion that a strategy needs to be developed along the lines of the Department of Health's "Listening to Local People" directive.

This has important consequences for the role of nurses now and in the future. If the actual needs have not been established to enable the choice to be made between the generalist and the specialist children's nurse, then the educational input into the academic and clinical curriculum in nursing courses such as Project 2000 becomes problematic. This dichotomy is addressed in this proposal by the generation of a needs assessment that will enable this decision to be grounded in the perceptions of both professionals and consumers.

Changes In The Preparation of Nurses For Practice

Project 2000 is the bedrock of far reaching and fundamental changes in nursing the United Kingdom today. It has affected and will affect the way nurses are educated and the way they will practice in the future (Robinson 1991).

Project 2000 aims to represent health care not only in the hospital but also in a variety of non - institutional settings. One of the most striking differences from previous nursing courses is that the student's role in meeting service needs has been minimised while the pursuit of academic achievement is emphasised. The student's achievements are rewarded by the acquisition of a Higher Education Diploma at the end of the course (Robinson 1990). This of course has the attraction of promises of even greater things in the future as the Diploma will give the student "kudos" in the higher education marketplace should she or he decide to pursue degree studies after

qualification. In Project 2000 the additional variable of supernumerary status is a double edged sword as far as practitioners and students are concerned. Rafferty (1992) states that:

> "supernumerary status removes the responsibilities and conflicts of the dual role with its inherent unrealistic expectations".

Luker (1984) alludes to the conventional belief that "there is an inverse relationship between intellectual ability and manual dexterity". It is interesting to note that in Robinson's 1991 study this belief was also expressed by students on a Project 2000 course who appreciated the value of increased knowledge and academic ability but felt it was gained at the expense of "practical or useful skills necessary to nursing" (Robinson 1991).

Project 2000 attempts to redress the balance in nurse education which was previously disproportionably weighted towards nursing care in hospital. The achievement of this is accomplished by the emphasis on students gaining experience in non-institutional settings. One of the aims for the child branch is to:

> "prepare the students to be competent professional practitioners capable of making specific nursing interventions to enhance the health and well being of children aged 0 - 16 years at all stages of dependency in a variety of institutional and non-institutional settings" (English National Board, 1989).

It is important to note that this is in conflict with the view previously expressed that nurses will need post registration education and training to adequately perform this role in the community.

At the inception of Project 2000 many nurses were concerned about the preparation of the new practitioner. Orr (1988) questioned the feasibility of putting even more students onto overstretched community placements. She analyses the costs and benefits to patients and to the strained community resources. Orr also refers to the worrying concept of using people as "living visual aids". She suggests that outpatient departments and transport rooms may be used as well as videos and case studies of nursing intervention to help students understand the skills involved in caring for people in the community.

Project 2000 students generally have limited opportunities to practice hands-on-care and Rafferty (1992) suggests that this may "produce a gap between learned theory and the opportunity to put it into practice". Rafferty further states that unless the total learning experiences are carefully monitored and acted upon, theoretical experiences will have limited meaning. Baker and Lane (1992) state that although child branch practitioners will essentially be able to work in:

> " a variety of settings the hospital environment is the most likely place for practice following qualification".

The question therefore arises as to why diplomates from the child branch would elect to practice in the hospital setting in preference to the community. The answer may lie partially in the lack of experience that the Project 2000 student has with sick children in the community. The indicators are that students spend a great deal of their time with health visitors. The Paediatric Community Nursing Forum (1991) states that

> "... health visitors and PCN's complement rather than replace each other because we do not possess the appropriate education and skills. Health visitors in turn have received only limited education in the care of sick children."

In the Project 2000 curriculum there is a much greater emphasis on health than previous nursing courses. Rafferty (1992) argues that despite the desirability of this focus there may be a mismatch between either

> "the students' perspective of nursing or the realities of practice".

Furthermore, she highlights that prospective nurses usually cite helping people and looking after the sick as the reasons for wanting to nurse. Rafferty cautions against creating

> " an expectation for a health model while in reality managing an illness one".

Rafferty concludes that the salient features of an emergent new professional are underpinned by careful planning of every aspect of the education of project 2000 nurses. Otherwise, Project 2000 nurses could emerge from the education process ill equipped to practise what they have been educated for and the profession will have prepared "an unmarketable commodity".

The question arises as to what the patients/clients and their relatives want of the nurse. McKenzie (1986) comments that the new nurse will be a practitioner who has been exposed to a "programme embedded in health and not in illness". He questions whether this is what the profession wants or needs and indeed whether the

> "public at large want these "new animals" stalking about

their backyards" (McKenzie 1986).

There have been criticisms of the way nurses have been prepared in the past and it was felt that the very nature of pre-registration nursing training militated against producing critical thinkers as well as knowledgeable practitioners. French (1992) proposed that

> "the pre-registration preparation of nurses was not an educational experience but that this produced practitioners who were uncritical replicators of existing nursing practice".

Moreover, the (more desirable) educated practitioner, as described by French, would need to be able to be "independent", use

> "numerous intellectual, interpersonal and practical skills to make decisions and solve problems in the interests of the patient". (French 1992)

Project 2000 appears to bear the hallmarks of an educational programme that provides the basis for producing such a practitioner. Furthermore, it appears that the work in the practice areas is the most influential variable in the development of the reflective nurse practitioner (Benner 1984). There has been an inevitable and apparent increase in the demands for professional knowledge in the practice setting. Nevertheless, it is clearly the case that no practitioner is capable of having up-to-date knowledge of all areas of nursing and given the rapidity with which knowledge becomes obsolete, what is required is adaptability. Schon (1983) contends that adaptability cannot be achieved if the emphasis is on the theoretical knowledge and she states that it is in the practice setting that professionals

acquire knowledge that is more relevant to problem-solving. French (1992) refers to knowing-in-action (knowing how) and reflection in action which is a progression in terms of development of a problem solving process which should take place as the course of study proceeds. Kratz writing in 1986 made reference to the fact that in relation to Project 2000 teachers will be the "linchpins" of the curriculum. She identified several areas that will be of prime importance to the teacher. For example , the preparation of students to work in previously uncharted territory such as supermarkets or working as au pairs in addition to the

> "... imaginative teaching of biological and behavioural sciences and removal of these from the environment of disease and disability".

She recommends that supporting and supervising students in these unstructured situations will have to be faced. Kratz (1986) states that recruitment of "large members of staff with a teaching and community background will be essential".

Kratz (1986) suggests that as the major part of the Health Visitor's work is with the under fives, she or he will have to be in the future a registered practitioner in children's nursing. In an interesting discussion she highlights the implications of the latter. These, it is suggested, would be accompanied by an increased demand for places in children's nursing with the difficulties and pressures associated with finding suitable clinical placements. Kratz questions the wisdom of the reintroduction of admission to the register for children's nurses only. She feels that it would be more appropriate for children's

nursing to be placed as a specialist preparation after registration.

Assessment of Project 2000 students in practice

As students become supernumerary and hospitals become trusts, the identity of the assessor is called more into question (Chandler 1991). She suggests that the definition of institution is becoming blurred and raises the question of the position of nursing within the realms of higher education. There is also the situation where the nursing staff on the wards are being asked to assess application of knowledge which they quite often have not themselves acquired. Chandler argues that assessment may in future be quite contentious as the problems of who can assess "integrative assessments between nursing and its specialisms" emerge.

Short clinical placements may militate against the student getting appropriate experience as students do not have enough time to conquer their anxieties in one area before having to move on. Furthermore, with changes in health care provision where hospitals opt out and become National Health Service trusts attitudes towards employment and training may be adopted which are more similar to those espoused by private enterprise. Chandler (1991) argues the case for commitment to the long term perspective in terms of training as opposed to short term "cost consciousness".

The re-organisation of nursing knowledge reflects the self examination of the discipline in general and a movement from training to education. Chandler (1991) examines the elements of these developments and discusses this in her article where she highlights that the move towards education signifies more discussion and critical evaluation "with greater onus being placed on the student to integrate and apply knowledge". If this is examined from the higher education perspective the recruitment patterns are dissimilar, the financial arrangements for students are different and education is interlinked with service-giving. The case being that recruitment is driven by "local manpower strategies" (Chandler 1991) and bursaries are given in the place of student grants.

In recognition of the differing needs of students Jinks (1991) alludes to the benefits of support for students such as mentors and liaison teachers in practice areas and feels that transfer of the same ideas to non - institutional settings where direct supervision may not be given by nurses, will prove beneficial. He also suggests that

> "... open forums for discussion/mutual support of staff working more independently in the community may also be useful".

It is difficult to predict whether completion of a Project 2000 course will make a significant difference to the nurse's ability to work independently and competently as a paediatric community nurse. There are two reasons for this assertion, the first is

that, as has been described above, there has been an uneven and pragmatically driven development of paediatric community services leading to unevenness in community experiences for students. Orr (1990) discussed the creativity of some Colleges of Nursing in overcoming these difficulties, although there are limited human resources and few backup services for support. Moreover, it is apparent that it is essential to ascertain the family's perceptions of need. It is difficult to establish the congruency between the education of the nurses concerned and the specific nursing care needed by children in the community.

Mangan (1992) reporting on the experiences of three nurses on one of the first Project 2000 courses described the apparent reticence of ward staff to make investments in students who they perceived were only there for short periods (two weeks). In addition, the students were also acutely aware that their acceptance into hospital culture was limited by their short placements possibly delaying their integration into the nursing workforce and therefore their acceptance.

Role of the Health Visitor in nurse education

In an examination of the perceived role to the Health Visitor and Project 2000, Ayton (1988) suggests that the health promotion and community work of the health visitor places her in a prime position in the education of these students. The health visitor, it is suggested, who will in the future be known as the "specialist practitioner in health promotion" will have a key role to play.

The Health Visitor's Association (HVA) (1987) in a response to the Department of Health consultation document recommended that

> "nursing students (were) to learn in an environment of care which is not only safe for patients and clients, but which their recovery and health is actively promoted; and one in which appropriate role models are offered to students in the form of qualified nurses who actually nurse."

The HVA recognised the need for students to be taught concepts of

> "community and normality while acknowledging the public's and nursing's expectation that the focus of nursing is the sick or dependent. Therefore, the curriculum should enable the student to learn about health at the same time as learning to recognise ill-health and abnormality (HVA 1987)".

Luker and Chalmers (1990) suggest that locus of control was an important variable in families' perception of health visitors.The reasoning being that if the families have an internal locus of control they may not require health visiting input. Alternatively they may believe that

> "their health is determined by chance forces and that action by themselves or other health professionals are of limited value in maintaining health. (Luker and Chalmers 1990)

Fatchett (1990) in a discussion of the future of health visiting argues that the shift to business management principles of the National Health Service is a real threat to health visiting. The reason being that it is difficult for health visitors to "improve their worth" in terms of measurable input and outcomes. Many studies have been undertaken in an effort to develop models to define and quantify health visiting and health visitor's work (Clark 1981, Lauri 1991, Twinn 1991) without finding an answer.

Baker and Lane (1992) state that although child branch practitioners will essentially be able to work in

> "a variety of settings yet the hospital environment is the most likely place for practice following qualification".

The question therefore arises as to why diplomates from the child branch would elect to practice in the hospital setting in preference to the community. The answer may lie partially in the lack of experience that students have with sick children in the community. The indicators are that students spend a great deal of their time with health visitors. The paediatric community nursing forum in recognition of this states that

> "health visitors and PCNs complement rather than replace each other because we do not possess the appropriate education and skills. Health visitors in turn have received only limited education in the care of sick children during their RGN training" (Paediatric Community Nursing Forum Dec.1991)

Foster and Mayall (1990) in a study of 28 health visitors in one district found that a top-down style of health education was used. The health visitors believed that there was "one correct way to rear children and they knew what it was" (Foster and Mayall 1990).

Parents in the study stated that they felt unable to talk to their health visitor because they felt that they were being told what to do and disliked the "authoritarian style" adopted. Mothers in the study also disliked health visitors who "undermined their own knowledge". It appears that some health visitors have a prepared script in order to deliver health information, a practice which is not always appreciated by the

client. Clark (1981) in a study of what health visitors do refers to the "didactic and authoritarian approach" which was one feature of the stereotype of the health visitor.

John Davis (1985) one of the pioneers of a community paediatric nursing service observes in a letter to the British Medical Journal the confusion that still exists between the roles of the nurses in the community setting. He states that Health Visitors have "increasing emphasis on sociology rather than nursing care and less emphasis on their intended role which is to "keep an eye on the well being of nursing couples and young children".

Davis (1985) notes that health visitors

> "are not required to have any experience of looking after sick children in hospital, do not undertake the immunisation of babies and children whose mothers fail to attend well baby clinics and do not lend a hand in the case of sick babies ..."

He suggests that given the "particular diagnostic skills as well as management skills" of the community paediatric nurse, this area should be regarded as a sub-speciality in its own right.

Davis (1985) suggests that there should be

> "a core of district children's nurses concerned with work in the home as well as in the well baby clinics and responsible for immunisation; development surveillance; support for mothers with unwell, sick or handicapped babies and children"

The identification of the perceived needs of children and their families

Health care providers have traditionally relied on their own perceptions of the consumer's needs in planning and developing children's health care, at the same time ignoring the consumer's wants (Pless and Douglas 1971, Rydberg and Merrifield 1984). It is apparent that this approach may be less than ideal for planning health care for children with ongoing health problems whose parents are assuming responsibility for their care.

Ong (1991) States that the basis of decision-making is the professional assessment of the clients needs, embedded in the "logic of nursing".

> "Through a careful matching of the multidimensional assessment of needs with the available resources outcomes and quality can be measured"

Understanding of the perceived needs of family care givers should be an integral part of the nursing management of the child with an ongoing health problem and his family. The question arises as to how the health professional in the community can identify the relevant needs of the patient or client. It appears that the perceived needs are

> "partly defined by the personal interpersonal and social systems of the patient" (Rawlins, Rawlins and Horne 1990).

It is therefore essential that nurses recognise the factors that contribute to that perception.

Pless and Douglas (1971) suggest that the focus must always be on meeting the needs of the parents and child not the needs as perceived by the professional. Nurses giving care to children

and families in the community must therefore be able to verify which needs are present in order that they can provide appropriate information, advice and support that will enable parents to manage their child's care at home.

Some researchers have developed tools to help identify the needs of families caring for children with long term illness or handicaps. Rawlins, Rawlins and Horner (1990), for example, developed a "Family Needs Assessment tool" as an

> "important aid to improving the nurse's perceptual accuracy in evaluating the needs of the family with a chronically ill child".

The focus of care for children with disabilities and special needs has also shifted from institutional care to care by the family. Simultaneously, medical advances have increased the longevity of children with often serious health problems and severe disabilities. These two sets of circumstances have resulted in families caring for children with

> "serious debilitating conditions often through adulthood" (Marcenko and Smith 1992).

A number of researchers have documented the impact of having a child with a chronic illness or disability on the family and highlight the

> "social isolation, stress, financial strain and difficulties in conducting normal family activities that they experience"(Marcenko and Smith 1992, Marcenko and Myers 1991).

The government has made forward movements in legislating for individual children with disabilities, for example, legislation for special educational needs (Children Act 1989). Marcenko and Smith (1992) found in a study of the needs of children with

chronic illness and or handicap and their families that the most essential needs cited were for respite care, nursing services and training in the care of the child.

Hymovich (1976) identified three tasks that mothers were called upon to accomplish in order to recover from the crisis presented by their child's ongoing illness, these were:-

a) to understand and manage the child's illness

b) to assist the client in coping with and understanding the illness

c) to meet the needs of all family members including their own and those of the ill child."

In order to accomplish these tasks Hymovich (1976) states that there are four of the family's needs which must be met, these are:-

a) the need for trust in themselves, their children and assisting health professionals

b) the need for information

c) the need for guidance

d) the need for human and physical resources to cope with the crisis.

Hymovich (1976) feels that these needs exist for parents irrespective of the type of illness, age of the child or therapy required. What would change would be the manner in which these needs are met which will differ with each family.

Wills (1983) in an American study of mothers of children with tracheostomies being cared for at home identified the psychosocial concerns experienced by these mothers. In her study, of 267 concerns expressed by mothers 119 were psychosocial. The areas of need identified were for support, reduction of isolation and limitations on time, the economic impact of the care of the infant, family interaction with the infant and provision of medical care.In Wills' (1988) study, most mothers felt that they needed help with their child, particularly in the early weeks at home. Although fathers were taught by the hospital to assist, they were at work for most of the day and so could provide only limited assistance.In relation to problems experienced by mothers giving care at home and communication with professionals, most mothers felt that the problems they were having were too trivial to call the doctor or the Home Care Co-ordinator at the hospital but they all felt that they needed to talk with a professional at some time. Wills (1988) reported that the mothers in her study felt that they were unable to leave their child with a tracheostomy in the care of anyone else resulting in diminution of social life and restriction on lifestyle. Some of the others reported the lack of time they had for their husbands, other children and themselves. Many mothers were upset by people staring at the affected child, or in other instances avoiding looking at the child altogether.

Whyte in a study of families of children with chronic illness in Edinburgh in 1992 found that families mentioned the following as important

> "giving information and explaining the meaning of investigations, answering questions, listening, providing a link between the clinic and the home and between the home and the school and providing help with child care".

It is important to recognise that parents may cite psychosocial needs as most important, having mastered some of the skills required to give physical care to their children. It appears that

> "Not only do parents become responsible for physical care giving, but they must become skilled in clinical assessment, clinical decision making and co-ordinating care" (Anderson and Elfert 1989)

According to Clark (1982) the process of searching for health needs and assessing them forms the central component of the decision - making process of the nurse. In relation to the community nurse decision-making is based on knowledge of both theory and practice and skills (Lauri 1989).

From the literature, it is apparent that parents caring for sick children have a variety of perceived needs. It would be foolish, indeed dangerous, to assume that because many of those needs expressed to researchers are psychosocial in origin, that there are no pressing needs related to nursing care. Patients with long term health problems and their relatives may be always loath to criticise or imply criticism of health care workers as they are aware of their needs in the future, this may be especially significant in the case of a child.

The policies related to identifying and meeting the health care needs of children are identified in the current Department of

Health (1990) Policy which is underpinned by the following principles:

a) "Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.

b) Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care."

However, the policy document stops short of addressing the issue of advocating a specific education and training programme for paediatric home health care nurses to facilitate the achievement of these aims in practice.

Nevertheless, small numbers of district trained paediatric nurses have been in existence for almost 30 years having first been established in Birmingham and Paddington in 1954. The number of teams has increased substantially recently and Whiting (1989) highlighted that there has been a 300 per cent increase since 1981. Atwell and Gow (1985) state that, although children comprise 20 per cent of the population, paediatric district nursing is not regarded as a nursing sub-speciality in its own right, the implication being that it ought to be.

It may transpire that in the future only the very acutely ill children will be admitted to hospital and for the remainder of sick or incapacitated children home nursing will become the accepted norm. Fradd (1990), Glasper et al. (1989) identified children with cancer, diabetes mellitus, cystic fibrosis or other handicapping conditions as the main users of home nursing services. However, Phillips and Robson (1986) highlight the

importance of the role of the paediatric home care team in Accident and Emergency and Glucksman et al (1986) describe the work of the team as having a very varied case load, including children with clinically acute conditions.

The Nature and Organisation of Learning Experiences for Students

Colleges of Nursing conducting Project 2000 courses have attempted to implement the English National Board's directive of ensuring that students spend 50 per cent of their time in the community. Hallett and associates (1991) found in their study that there has been a "considerable expansion in the amount of community experience offered in almost every demonstration district". They also highlight the difficulties experienced by some colleges in finding community placements in sufficient numbers for the students on Project 2000 courses. This became especially apparent as courses progressed and subsequent intakes swelled numbers. Hallett and Associates reported that community staff were initially disconcerted by the changing nature of the experiences they were requested to provide in the light of evaluative feedback from students. As a consequence, community staff experiencing some uncertainty related to planning practical experiences in the community. The English National Board's Guidelines on Practical Experience in Non-Institutional Settings (circular 1989/28/RMHLV November 1989) 2.2 states that

> "... on qualification, nurses will have considerable knowledge and awareness of the delivery of care in non-institutional settings. The nursing skills employed in these settings will be essentially the same as those required in institutional settings. The nurses' approach will need to be flexible. They will be expected to work

and maintain continuity of care in a variety of settings. They will need to know how the services can be provided in the health care system."

If students are to work in a variety of settings and utilise the same skills as those "required in institutional settings then by implication the community experience must be gained with patients and clients requiring nursing interventions of differing kinds and differing levels. This would suggest that the community experiences of the Project 2000 nurse should be gained by working with specialist or advanced practitioner. Hallett and Associates (1991) found in their study that the practice of students "negotiating" their non-institutional practical experiences resulted in

"a considerable amount of freedom and flexibility in some districts."

Theoretically this should be a good position for students to be in, in terms of meeting their individual needs. However, Hallett and Associates highlight the potential difficulties of identifying specific goals on the part of both students and staff. In addition, the logistical implications of monitoring or controlling these activities on a large scale are difficult to envisage.

The Influence of Market Forces on Nursing Education

The British National Health Service is currently going through a period of radical change. This change is as a result of the government's White Paper "Working for Patients" published in

January 1989. According to Rathwell (1992) the proposals for change have been unprecedented in the history of the National Health Service. The changes comprise the creation of self governing hospital trusts and community units under the control of the National Health Service (NHS) trusts; organisational separation of purchaser and provider and a different method for allocation of resources (Rathwell 1992, Barrett and McMahon 1990). The District health authorities will be able to specify the quality and quantity of health care services they require for the population that they serve from provider hospitals to other units.

Eligible general practitioners will be given budgets with which to treat their patients and or buy hospital or other care as necessary. Sims (1993) argues that rationing is being implemented by "stealth". The new focus on quality, value for money and cost containment will inevitably mean that length of stay in hospital will be a key factor in the purchaser/ provider dichotomy. Latham (1993) in a paper on the NHS quotes Tim Baker who is the business development manager of Norwich Union Health care as saying that length of stay alone could account for a lowering of costs by as much as 10 per cent.

The recent Kings Fund/BMA/Patients Association survey of 800 doctors, 3,000 senior NHS managers and 2,000 members of the public revealed that childhood immunization came top of a list of 10 items for ranking in order of importance. Mills (1993) argues that change should not be made for its own sake and while

he welcomes the new relationships forged as a result of the purchaser/provider systems questions must be asked as to whether providers can "... sustain clinical services throughout the financial year".

Mills (1993) discusses the strategy of looking at more ways of providing services outside hospital but cautions against the substitution of acute inpatient services. He feels that

> "... putting into practice any expansion of primary and community services will need careful handling".

Salter (1993) in a paper examining the politics of purchasing in the National Service states

> "... with the 1992 NHS reforms and the introduction of the internal market a new political game has begun where, for the first time, the rationing of health care to make it fit unlimited demand is the explicit responsibility of purchasing agents (DHAs, FHSAs and GP fundholders)."

He argues that rationing has been present since the inception of the National Health but it took place in the form of delays in referrals from General Practitioners to consultants, between one consultant and another and via waiting lists. Furthermore, there has never been any actual

> "definition of the nature of health, illness and care and what is or is not the responsibility of the state." (Salter 1993).

It appears that the current NHS reforms now advocate explicit rationing and as Salter argues the focus initially was on providers with purchasers "largely left to their own devices". The most burning political issue appears to be how to decide on the "volume and type of health care" to be purchased (Salter 1993).

The "purchaser" function consists of the identification of health care needs, priorities and standards within a defined population and the direction of financial resources accordingly (Harrison and Wistow 1992). The purchasers are the District Health Authorities (DHAs), Family Health Service Authorities (FHSAs) and fund-holding General Practitioners (GPFHs). Providers are hospitals, community health services, ambulance services etc. In addition, some of these will be directly managed units, or may be self governing trusts. The two parties are linked by contracts for services (Harrison and Wistow 1992).

The role of the DHA is to identify the needs of their local populations and then "purchase the health care to meet those needs" (Salter 1993). Salter suggests that "needs assessment might prove to be a political and technical morass" which was the conclusion reached based on the findings of a paper "The Role of District Health Authorities - analysis of issues." He further states that

> "... every conceivable factor relevant to the assessment of population's health care needs is listed but no indication is given as to how the different factors should be related or highlighted in order to arrive at a decision".

Salter feels that with the publication of two documents on factors to take into account in the assessment of the population needs

> "... open season existed in the needs assessment category of the new political game."

According to Moore (1993) a situation has developed in Oxford where patients from outside the district are able to be treated with sophisticated technology and expertise while patients in Oxford have to remain on waiting lists as the Oxfordshire Health Authority cannot pay for their treatment (Hall and Prendergast 1990). The development of service agreements between purchaser and provider should highlight the need for co-operation and flexibility in the use of beds and community resources.
The new contract for GPs encourages them to take over child health surveillance, which along with health promotion is a part of primary care.

Conclusion

It appears from the literature surveyed that Project 2000 has necessitated a major shift in nursing, with the emphasis, in the Common Foundation Programme, on health rather than ill health. This has had to be accepted by the students, the teachers, practice staff and the patients. Several related issues have emerged such as the finding of suitable clinical placements for students in the community and child health.

The current emphasis on optimising resources in the NHS, and the move towards patient/client empowerment has resulted in a genuine effort to reduce the duration of hospitalisations for patients in general, and children in particular. It has been shown that, given the numbers of children under five who are admitted to hospital, there should be more provision for children to be cared for in their own homes with the support of qualified children's

nurses. Despite the findings of a number of reports since the Platt Report in 1959, there has been little headway in the development of a national community service for children.

Some authors argue very persuasively that the nurse trained to work with sick children in the home environment needs to have a set of skills in addition to those of the hospital nurse. The specific skills cited include a high level of practical, teaching and interpersonal skills. It has also been suggested that the preparation of home care nurses should include hospital experience with patients of the same type as those he or she will encounter in the home. This is to increase competence and confidence in skills such as physical assessment and the management of technical devices. She or he, therefore, needs advanced skills in caring for children with a wide range of illnesses. This suggests that post registration education and training are essential for children's nurses if they are to become expert in the care of children with a wide range of illnesses in their own home and without the immediate support of colleagues.

Project 2000 has been developed as a response to the changes necessary to meet perceived future health needs in society. The ethos behind Project 2000 is to equip nurses to work in either the hospital or the community. In terms of children's nursing, this philosophy is at variance with the views of a number of expert paediatric nurses who feel that the nurse caring for children in the community must have the skills to act in an

advisory capacity, as well as handle an emergency situation should it arise.

It has also been shown that the student on the Project 2000 course should have the theoretical background to enable them to be critical thinkers, reflective practitioners and knowledgeable 'doers'. However, it is felt that they lack the appropriate experiences in the community which will enable them to care for sick children and their families in this milieu. The question of supervision and mentoring has been considered and many writers have expressed reservations about the validity of the almost exclusive use of health visitors as mentors on community placements, given that the vast majority of health visitors have no experience in the care of sick children in the community. The literature also suggests that the communication style of some health visitors does not indicate an appreciation of the individuality of the child's family and demonstrates a lack of flexibility in approach which has been described as a "prepared script" from which they are unable to deviate.

The literature review highlighted the possible problems associated with the assessment of Project 2000 students. Areas of concern were the differences in educational experience of the assessors in the clinical areas, and the short duration of placements which adversely effect socialisation of the student into the hospital and the ward. The shift in emphasis in the National Health Service and the new willingness to espouse market principles are considered by some writers to have potentially

deleterious consequences for the mentoring and assessment of students. Furthermore, a number of writers suggest that the shift to the business ethic by the NHS poses a threat to health visiting because of the difficulty health visitors have with measuring their work in terms of input and outcome. This has implications, therefore, for the future availability of mentors and assessors.

The literature reviewed, identifies the significance of needs assessment in providing appropriate care for children and their families. It has been shown that families with children with continuing health problems have specific psycho-social needs which must be met with sensitivity and care if the fragile relationship between client and professional is to be maintained intact. The needs of sick children are currently met, primarily, by three models of community provision for sick children: the clinical specialist practitioner who works in the hospital and visits children in the home situation: the community paediatric nurse: and the paediatric outreach nurses based in hospital or community, and operating from there. The literature indicates that the development of these services is uneven, nationally, and that the current Health Service reforms will not necessarily result in this pragmatic development becoming more directed.
We have argued above that:

1 There is an uneven, pragmatic development of community health care services for children with no clear national perspective.

2 There is poor information about the community's needs.

This lack of information is both statistical; what numbers of children need sick children's nursing in the community and phenomenological; what needs are perceived by the children and their families.

3 There is therefore a problematic role for paediatric nurses, with contradictory messages about their role focusing on the health problem child with an acute or ongoing health problem.

4 This will impact on the preparation of the children's nurse for two reasons, the confused pattern of role models that will present in community placements, and the role confusion that will arise as a direct result of this.

The Research Questions

The general questions that are addressed are:

1) What needs are perceived by families and nurses for specialised nursing of children in the community?
2) What services are provided?
3) How do the children's nursing courses prepare diplomates to meet these needs?

The specific questions relating to 3) are:

1. What is the core experience that Cb students have in the community?
2. What are the placements that provide this experience?
3. What professional groups act as mentors and assessors during the community experience.
4. What experience do the college teaching staff have in community nursing?
5. What links exist between the community and the educational staff?
5. What community services are seen to exist in the colleges by each college?
6. What difficulties have colleges had in securing community placements?

METHODOLOGY

Design

The project had a design consisting of three elements:

(a) A postal survey of those colleges of nursing currently conducting the branch programme for children's nursing.

(b) Interviews with Child Branch tutors, students and involved community nurses at 4 colleges conducting the Child Branch.

(c) An assessment of the perceived needs of children and families in relation to children's nursing.

This design was selected in order to first, generate a national picture of the course philosophies, structures and clinical experiences offered during the Child Branch. Second, to explore issues arising from this in greater depth at colleges who had started or were en route to commencing the Child Branch, and third, to put this data in the context of the sort of issues seen by families, children and their community nurses.

Ethics

There were two central ethical issues to be considered. The first is that the data precludes anonymity for the respondents in the colleges of nursing both for the survey

and the four centre interviews. Confidentiality was therefore assured in the initial approach, and confirmed before the interviews took place in the case of the centre interviews.

The second issue is that informed consent needed to be obtained from the families that were interviewed. Approval was obtained from the relevant health authority Ethics Committee to conduct the study in their area and the form of consent was endorsed (see appendix 1). The only condition made was that the families of children with leukaemia being treated at a specified hospital were omitted to avoid undue demands on them because they were already being interviewed by another research team.

All parents were asked to sign the consent form after being assured of confidentiality with the understanding that nothing they said would have any impact on the child's future treatment and that they could stop the interview at any point.

The Survey of Colleges of Nursing

The Population and Sampling Issues

The determination of those Colleges of Nursing[1] that were delivering or planning to deliver a Child Branch was done from information from the ENB and the Nurse's Central

[1] College of Nursing will be used as a generic term for those colleges delivering P2000 courses

Clearing House handbook. It was estimated that, at the cut off point[2], there were 43 colleges who were in varying stages of developing a Child Branch programme. This means that there were colleges for whom the branch programme was up and running and colleges who had the programme validated but the branch students were still in the Common Foundation Programme.

Because 43 colleges does not constitute a large population for the survey it was decided to question all the colleges rather than to take a sample. This has the advantage that complicated stratification schemes do not have to be developed because of the small sample and that the issue of sampling error with small samples is side stepped. It can be seen from Table 1 that the response rate was 81% which is reasonable.

TABLE 1 The Response Rate of the Survey

RESPONDERS	NON-RESPONDERS	RESPONSE RATE
35	8	81%

Twenty four of the respondents had started the Branch Programme, and eleven colleges had a validated programme with students on the Common Foundation Programme en route to starting the Branch, as can be seen from Table 2 below.

[2] This was June 1st 1993. A cut off point was selected because of the continuing cycle of validations of child branch programmes.

TABLE 2 The Status of the Child Branch Programme

STARTED*	NOT STARTED	TOTAL
24	11	35

* Colleges that had started the Child Branch at June 1st, 1993.

The Questionnaire and its Development

The instrument was developed by an initial selection of appropriate questions from the literature, the project specification and by piloting the draft questionnaire at two colleges. The questionnaire was sent to the colleges and then each college was visited and the leader of the Child Branch was interviewed by members of the research team. These interviews were recorded using notes and took the form of going through the responses to each question and then looking for ambiguities, omissions and duplications of data. From the pilot the questionnaire was substantially modified.

It was found that the original concept of a large number of open questions was appropriate because of the wide range of possible responses to, for example, the sort of community placements in the Common Foundation Programme. There were further ambiguities to do with concepts such as non-institutional in reference to placements, where one of the colleges felt that this was defined as non-NHS, the other as non-hospital. The final questionnaire is shown in appendix 2.

It could be argued that a more structured format for the questionnaire could have been used. The issue here is the complexity of the data and the subsequent length of any questionnaire. The second assumption is that such a questionnaire presupposes that all the categories are available and at hand. One finding from analysing this data is that there is a considerable range of interpretations of terms like mentor, community, teacher, tutor and even assessment and supervision. With a large population of colleges it might be feasible to attempt a pilot of sufficient size to generate most of the questionnaire categories. We would argue that this is not possible with a relatively small population of colleges delivering or planning to deliver the Child Branch.

Data Analysis

The data was analyzed by constructing a coding frame for each open question (Moser and Kalton 1971) and collating descriptive statistics for both these and the closed questions. SPSS was used for statistical analysis.

The Procedure

The Principal of each college that had been selected was written to asking for the name of the person managing the Child Branch and for permission to contact them (appendix 3). These contact persons were then sent the questionnaire

with a covering letter (appendix 4). Those colleges that had not replied after 2 months were sent another letter requesting that the questionnaire be completed.

The Four Centre Interviews

From the survey four centres were identified for in-depth study. This study involved a series of focused interviews being undertaken with students, mentors and teachers involved with the Child Branch programme. The purpose of these interviews was to examine in detail questions that had been asked on the survey; to flesh out the data and to give the perspective of the students, tutorial staff and mentors involved in the programme.

The Sample

A maximum variance purposive sample (Quinn Patton 1987) was used. Here the sample consists of those centres that exemplify the sorts of core community experiences that were identified in the survey of the colleges. This sort of purposive sample has the advantage that by using such cases the main theoretical issues can be clarified. How representative such cases are depends on the adequacy of the sampling frame used to select them. In this project the sampling frame used for the selection of the four centres was based on three continua of course provision identified from the survey data (see the results section, especially Table 4).

Centres which have commenced the Programme.	Centres who do not yet have the Child Health Branch, but are approved to do so, and have commenced Project 2000.
Centres providing a significant period of community nursing experience with children.	Centres not providing a significant period of community experience with children.
Centres providing community experience with a specialist Paediatric Community Nursing Service.	Centres providing community experience with Health Visitors.

Significantly, it proved very difficult to identify a centre which used the Paediatric Community Nursing model and which was far enough into Project 2000 to have students who were within the Child Health Branch Programme.

The general characteristics of the four centres selected were:

Centre 1: **Students with Child Health Branch Programme.**
Provided only a limited period of community experience.
Provided community experience with the Health Visitor Model.

Centre 2: **Students not into Child Health Branch but has commenced Project 2000.**
Intend to provide a significant period of community experience.

Intend to provide community experience with the Paediatric Community Nurse Model.

Centre 3: **Students into Child Health Branch Programme.**

Provided a significant period of community experience.

Provided community experience with the Health Visitor Model.

Centre 4: **Students into Child Health Branch Programme.**

Do not provide a significant period of community experience.

Provide community experience with the Paediatric Community Nurse Model.

These centres allow, therefore, the examination of the educational organisation of the core community experiences isolated in the survey of colleges.

The Pilot

Prior to the commencement of the focused interviews the researchers organised a series of group discussions with Health Visitors, District Nurses, School Nurses, Clinical Nurse Specialists from the Children's Nursing Service, some of whom had outreach aspects to their roles and Paediatric Community Nurses. The group discussions were arranged to develop the researchers' theoretical sensitivity and to discuss issues which may arise in

relation to the proposed research methodology. The discussions focused on developing a clearer understanding of the different practitioners' perception of their role, particularly in the care of children when they are ill and require nursing intervention. The discussions also focused on the issues related to the provision of services for the care of children in the community, especially those who are experiencing illness.

Procedure

The course leader at the selected colleges was contacted and arrangements made to interview as many of the students, tutors and community nurses who would be available.

The method of data collection for the in-depth study was the focused interview. Three to five focused interviews were undertaken at selected centres and a total of 18 focused group interviews were undertaken at the four centres. One interview at each centre must have been with a teacher, a student group and a mentor. Wherever possible interviews were undertaken on a group basis. This was done for several reasons. The first is that because there is a danger of self selection of subjects, or a biased selection if a sample is taken of students and staff where the researcher doesn't have control over the access to interviewees. It was requested therefore that all the students on the branch programme and all the tutorial staff be included in the groups. While this does not remove bias

as some students, for example, did not present for the interview, it does reduce the bias due to selection by the contact person. It also enabled maximum utilisation of available time and facilitated a wider range of experience and views to be gained. The group interviews also proved helpful in terms of making students, especially, feel at ease.

The details of the interviews for the four centres are as follows:

Centre 1: 3 group interviews with 4 tutors from the Child Branch, 6 students from the Child Branch and 3 paediatric community nurses.

Centre 2: 5 group interviews, two groups of students on the Child Branch (3 and 5 students), one with tutors (4) on the Child Branch and one with community mentors and assessors (3 Health Visitors).

Centre 3: 4 group interviews, one group of tutors (3), two groups of students (8 and 6), and one group of community mentors and assessors (3 Health Visitors).

Centre 4: 6 group interviews, three groups of students (5,6,4), two groups of mentors (3, 3, Paediatric Community Nurses), and one group of teachers (2).

The focused interview was used because we wished to direct the interviews to specific themes that had arisen from the

results of the literature review and from the survey data (Merton and Kendall 1946). In doing this the suggestions of Cohen (1980) to reduce any possible bias were adopted: questions were carefully formulated to ensure clarity and steps were taken to ensure that the interviewers were adopting similar procedures.

The focused interview should also enable the discussion to be limited to only certain relevant parts of the respondents experience. Cohen (1980) argues that the focused interview has certain advantages over other interview approaches and these can be specifically described in terms of this research study being undertaken as:

1. The persons interviewed are known to have been involved in a particular situation.
2. Significant themes have already been established from the literature review and the survey data
3. The actual interview is focused on the subjective experiences of the persons who have been exposed to the situation.

The focused interviews explored, in-depth, the educational process that is used to prepare the students for their future role. The interview focused on their experiences within the educational process that was specific to the centre and especially experiences undertaken within the community.

The specific areas that the interviews focused on included:

1. The links between the children's service and the educational establishment.
2. The perceptions of the community services of the relationship between the educational programme and the role of the children's nurse.
3. The nature of the relationship with other community services.
4. The perceived changes in the role of the children's nurse over the next decade that will impact on the curriculum.
5. The students' experience of the branch programme.
6. The tutors' experiences of organising and conducting the branch programme.

The interviews were recorded on audio-tape and the interviewer also took field notes. The researchers who facilitated the focused interviews undertook some interviews on a joint basis to ensure that the interviewer's style was as consistent as possible throughout all the interviews. Briefing and de-briefing sessions were undertaken, by the researchers, at the commencement and conclusion of each set of interviews so that experiences could be shared and contextual issues identified, discussed.

Data Analysis

The tapes were transcribed and the Ethnograph (Seidel 1988), a programme for the computer assisted analysis of text based data, was used for organising the coding of the scripts. The content analysis was organised around the central questions referred to in the section on the focus groups. The data was examined for typical experiences that would illuminate the responses obtained from the survey. In particular the responses were used to attempt to construct some explanation of the survey data. The transcripts were read by the team and a negotiated account of the concepts, categories and sub-categories was constructed; an account in other words where each rater agreed with the categories and themes that had emerged from the analysis. The issues of reliability and validity that are relevant to this are discussed more fully in the section below dealing with the analysis of the needs analysis data.

The Needs Analysis

The traditional approach to the assessment of health needs within public health, and, by extension, purchasing as a whole, has been to do some kind of survey of users' views. However, it is increasingly being recognised that traditional research approaches to collecting information simply cannot match up to these requirements. Purchasers and providers have become increasingly aware of the value of qualitative research on small numbers of people to

generate a deeper understanding of the needs of health service users (Pickin and St. Leger). We decided that such an approach would be a fruitful way of finding out about the needs of parents with sick children with regard to nursing care.

In this study we have used the method of purposive or theoretical sampling to select a small number of respondents or cases for in-depth interview. While it will not be possible to make statistical inferences from this sample to the universe from which they are drawn ie. families with sick children, our aim is to draw out the key features of parents' perceptions and to get some sense of the strength with which views are held about different needs and services. Through a process of analytic induction (Yin 1984) we hope to be able to make logical inferences from the accounts we have collected to a thematic universe of health needs. Analysis of these data will provide the basis of an informed discussion of the nurses educational requirements of children's nurses.

Sample

In view of the theoretical aims of the project, sampling was undertaken on purposive rather than statistical grounds (Strauss and Corbin 1990). The intention of this part of the investigation was to select parents of children with a variety of illnesses being cared for in a range of different circumstances. Clearly it was not possible for

us to take account, in our sampling procedures, of every variable that might be of relevance to parents' experiences of need in relation to the care their children. However, we have been able to interview a range of parents whose children have either chronic or acute conditions, being cared for in four care contexts: specialist nurses, community paediatric teams, district nurses/health visitors, or nobody. The conditions included diabetes, thalassaemia, cystic fibrosis, tracheostomy, minor surgery, and fractures. The logic of the sampling, therefore, was to select people not because they could be said to represent some wider universe or population, but because the health needs they expressed represented important and salient aspects of the delivery of health care to people looking after sick children.

We have interviewed 13 parents, mostly mothers, of children with a range of conditions. These parents were selected through our contacts in hospital and community nursing in a specified geographical area. In this a variety of services are available including both community and hospital based Paediatric Community Nurses. The only criterion applied in the selection process other than the chronicity of the condition and the type of current health service contact was that the parents should be willing and able to talk to us about their children. While most people contacted have been very happy to be interviewed, and we have had no outright refusals, there have been difficulties

in one of two cases in arranging a time that was suitable for both the interviewers and the respondents.

We also interviewed 4 specialist and community paediatric nurses for the purpose of obtaining some comparative information.

Interviews

The interviews themselves were semi-structured. There are many different definitions of interviewing based upon the degree of 'structure' they purport to contain. Much of the methodological discussion of this topic seems to us to over-complicate a rather pragmatic problem. In essence it is helpful to conceive of different kinds of interviews as existing on a continuum, rather than defining them categorically. There is also a lot of confusion in the literature about the different uses of terms such as structured, standardised, and focused. The interviews we conducted with both parents and nurses did not make use of an interview schedule which remained unchanging from one case to the next. In that sense they were not structured or standardised. However, the content of the interview was naturally focused around a child's health and ill-health, and parents perceptions of the care they had received from nurses and other health service staff.

Issues of reliability and validity

There is always a legitimate concern in interviews of this kind about interviewer effect or interviewer bias. In conducting the interviews in the way we did there is always the danger of putting words into the mouths of respondents if for no other reason than to keep the interaction going. All the people engaged in interviewing were fully apprised of the importance of not allowing this to happen. In addition, we used a number of different interviewers in order to make sure that there was no systematic affect upon the interviews of factors such as gender, or whether or not the person doing the interviewing was a nurse him or herself. We therefore feel confident that the data collected fairly represented the views of the respondents we have interviewed. In one sense, however, there were 'biases' that were impossible to control out. These were the emotional responses in the interviewers to the parents' descriptions of the experiences they had undergone looking after their children. For those interviewers who were themselves parents, there was a sense in which they were drawn into a world of experience that they 'understood', even if the components of that experience were very different from their own.

As researchers we had a set of issues or topics that we wanted to cover in each case, and we used these to provide the basis of a guided conversation in which would be able to collect the information we wanted while allowing parents

to express their views in their own terms. The main areas covered in the interview are:

1. Perceptions of the nature and severity of health problems
2. Health care needs
3. Other health and social needs
4. Ideas about how care could be improved
5. Views of the training needs of those providing care

All the interviews except one were tape-recorded. Tape-recording interviews introduced another set of possibilities for error. It is impossible to know for sure whether the presence of a tape-recorder suppressed the quality and quantity of the responses we received. However, we felt that the kind of accounts we were eliciting were of a density and richness that it would have been extremely difficult if not impossible to conduct this part of the research at all with out the use of audio-tapes. In every case except one the quality of the recording was sufficient to allow complete transcription of the material by a trained audio-typist.

Data Analysis

The analysis of interview data, like the conduct of interviews, is an enormously complex task. However, also like interviewing, the descriptions of 'how to do it' are often rather unhelpful because they reduce the complexity

of the process to a set of technical procedures which it is then extremely difficult to re-apply in a different case. Although there are many ways in which the analysis of qualitative and quantitative data are very different, the data collected for this part of the research are similar to quantitative data in the sense that they can be subjected to many different interpretations, and to many different levels of analysis. Just as in quantitative analysis it is advisable to examine frequencies and cross-tabulations before proceeding to anything more complex, so with qualitative data it is advisable to think about the content of the data within the language-terms of the respondents themselves before translating it to a 'higher' conceptual level.

It is also important to recognise that the 'depth hermeneutics' involved in the analysis of qualitative data is very time consuming. It requires both intensive individual effort, and collaboration between individuals to ensure that the interpretations being placed upon the data are not idiosyncratic. Although we have used the overall approach recommended by Glaser and Strauss (1967) in their work on 'grounded theory', the analysis of the data presented here is very much preliminary. There is much more that could be done with the data, and we have stopped at that point we felt was necessary to make a contribution to the overall quality of the project.

The data produced are being subjected to detailed content regarding the main themes. The interviews are being analyzed separately by two researchers in order to control for bias in interpretation. Differences in the coding are discussed in detail with a view to arriving at a consensus. While this does not allow us to say that our interpretation of the data is valid in some absolute sense, we do feel reasonably confident that what we present here is a reasonable reflection of what our respondents told us.

RESULTS

To understand the significance of the results of the survey and the in-depth interviews in the four centres it is necessary to put them into some context: that context is provided by the data reported below from the interviews with families about their experiences of nurses and their perceptions of the sort of health care that they need.

The Context of Community Paediatric Nursing: The Assessment of Needs

The presentation of the findings is sub-divided into the following sections:

1. Parents' experiences with sick children
2. The nurse in the parents' social context
3. The dimensions of need
4. The implications of the findings for community paediatric nursing.

Parents' experiences with sick children

At a personal level the experience of looking after sick children is dominated by two feelings: anxiety and fatigue. In that sense, looking after children who are sick is, for parents, like looking after children who are healthy, with

a number of 'multipliers' added into the equation. For example, children are always unpredictable in mood and behaviour because the practice of being a parent, running a household, and doing a job outside the home involves the imposition of regular routines. This tension between 'anarchy' and 'order' is part of what makes parenting the tiring experience it is. However, when a child is diagnosed as 'diabetic', or when the parents are put in a situation of having to go time and again to see their general practitioner (GP) with a sequence of vague but disturbing symptoms of unknown cause, anxiety and fatigue become accentuated.

For example a mother of a child who was eventually diagnosed as having diabetes went through a series of visits to her GP over a period of about a week because her child was vomiting. She kept her daughter off school for two days and when there was no improvement on the third day:

> "I rang the GP and she said there was this bug going around, and not to worry and she would leave me a prescription" (11.1).

The symptoms continued with the child becoming more and more dehydrated. On the Friday she was still being told she was 'fussing over nothing' (11.1). They phoned again on the Saturday morning and a GP came to see them at about

1.00 p.m. After examining the girl she told the parents that they did not need to take her to the hospital, but that if she was still ill on Sunday they could do so. The parents were not happy with this decision and took their daughter to the hospital on the Saturday:

> "And when we got there the doctor said: "what took you so long? Can't you see this child is ill?" (11.3).

For those with acute conditions the experiences of anxiety and exceptional fatigue were short-lived. One mother whose boy had been circumcised had been very pleased about the care received in hospital but had been surprised when she had no visits from the health visitor afterwards (7.5), and felt she would have benefited from some discussion with someone about post-operative care.

The anxiety and fatigue experienced by parents are related to the fact that for them their child is a person of significance. Many parents dealing with children with chronic problems had developed ways of managing their anxiety and coping with fatigue. They had learned, for example, to become absorbed in the technical aspects of their caring role. However, the fact remains that for parents the process of caring for a sick child is a moral as well as a 'clinical' project. For this reason fatigue was not necessarily directly related to the amount of clinical work they had to do: it was central to the caring

relationship. Similarly, a mother of a child with cystic fibrosis who was being treated as 'terminal' managed to suppress some of her anxiety and sadness by focusing on the many technical interventions required by her son.

The nurse in the parents' social context

Although the focus of this research was on the role of nurses in caring for sick children, it is important to recognise that from the point of view of the respondents in this study the GP is usually the first point of contact with the health care system and that nursing is only one of a number of resources upon which they are able to draw at different points in the illness career of the child. People not only exist in situations or contexts, their actions are determined to a great extent by the qualities of those contexts. While the focus of our interest, therefore, is parents' perceptions of the role of nurses, for our respondents the perceived problem was often the more general one of the mismatch between their perceived needs and the resources available around them.

The process of looking after a sick child for many parents includes a growing recognition that medical and health care opinions are not 'scientific facts', and that the kind of clinical and social response of different health care practitioners varies considerably. The implications of this for parents perceptions of their own role is that they

realise that they have to do a great deal of 'interpretive work' of their own in making decisions about what to do in different circumstances. Illness behaviour, in this context, is a highly complex process of examining information from a number of sources and making decisions which are often no more than a 'best bet'.

For example, for another respondent whose child had diabetes, the fact that her husband was also diabetic immediately altered the way in which the symptoms were perceived and their attitude towards the care they were offered. The husband's knowledge and experience was part of the resource-base within their context which affected their expectations of the health care system.

The findings from this part of our study support those of Bie Nio Ong (1991) in her study of researching needs in district nursing where she argued:

> "If district nurses are serious about understanding people's needs, they have to acknowledge that these needs are socially constructed and closely bound up with identities and expectations".

In other words, neither felt needs nor demands for services leap out in some unproblematic way from the pages of our transcribed interviews. They are part of the daily round in which people seek to resolve problems by making use of

a wide range of informal and formal sources of care.

We have found that the role played by specialist nurses from the hospitals is very complex. Indeed, they are expected to play a variety of different roles at the same time. While the parents like them because they show specific competence in relation to technical aspects of treatment there are other facets to the relationship. For example one mother of a fifteen year old boy with spina bifida said:

> "It's nice because you can ring up and have a chat with her, and she can advise you, not like a nurse, you know..." (11.5).

The same woman also described the important role the nurse played in acting as a mediator between the lay world and the clinical world of the hospital consultant:

> "When I go [to see the consultant at the hospital], I don't know how to word it. I don't know the word and she will do, and I feel I get to know more because [the nurse] will interpret it for me in her nice posh way"(11.12).

In being under the care of hospital staff the parents of the chronically ill children have made little use of the community nurses and primary care teams. However, what has

also emerged is that very often the reluctance to make use of the GP, district nurse and health visitor is based on a feeling that they are not interested in helping or they are not competent to do so. Another mother told us: "I think really [I would have liked someone] to come in and to reassure me that I was doing things right". Our data also show that for these parents of children with chronic health problems, respect for their own detailed knowledge of the child's condition is sometimes not as obvious as they would like it to be.

For health visitors it was more easy to be seen as superfluous because they were not perceived to have a particular area of technical skill. However, the interviews clearly indicated that in situations where the health visitor, or the district nurse, was able to perceive the parent's and children's needs in a broader context, and especially in situations where technical skill was not crucial, they could fulfil a very important role in the lives of these people.

The Dimensions of Need

On the basis of the data we have collected there seem to be six broad areas of need. However, these areas are inevitably not discrete. Information clearly overlaps with communication, communication is clearly related to support, and support may involve link-working. However, we have separated them for analytical purposes in order to show the

various facets of a very complex experience.

The need for information

Many parents spoke of the need for good quality information. This included a need for information and advice about a particular condition such as cystic fibrosis or spina bifida. The information required was both technical and practical. It included both information on drugs and equipment, and on practical tasks such as feeding and bathing.

For example, one woman whose child was in plaster from the waist downwards when he was eighteen months old had a major practical problem in how he should use a potty. When she was asked by the interviewer whether she had been shown how to do this she said:

> "They did give me an idea but not....I sort of worked it out myself in the end. It was trial and error in the end [....]. We had to do a lot of running on our own initiative, you know, [...] and I think I'd have liked a bit more help" (2.3).

When she was asked what kind of information and advice she needed at that time she told us:

"I think really just to come in and to reassure me that I was doing things right because....I was still a new-ish mum. I wasn't sure I was doing things right" (2.4).

While some of the information needs of parents is for technical information that can be provided in leaflets or fairly straightforward verbal instruction, such information is inevitably abstract and general. What is still needed, from the recipients' point of view, is some kind of context of interpretation in which the information can be translated by them into useable guidance. Discrete items of information sometimes do not help to reassure the parent that they are doing things right. The use of the work 'right' in a number of interviews serves to underline the point made earlier that for the parents the process of caring for their children is both a technical or clinical and a moral project. Parents wanted information that helped them to know that they were doing things in a technically correct way, and that their whole approach to caring was right in a broader sense.

In some cases where the condition is clearly defined, and one for which a large amount of highly codified nursing knowledge exists, such as in diabetes and cystic fibrosis, which have their own specialist nursing practitioners, the problem was less an absence of knowledge, and more one of how to absorb, interpret, and make use of a large amount of information. One mother had been taught by the hospital

nurse to do suction on her child who had a tracheostomy (6.1). Another mother, who was herself a district nurse, whose ten year old son had been diagnosed with diabetes twelve months before, spoke approvingly of the information she was given from a dietician, a diabetic nurse, a consultant, and the nurses on the ward:

> "Well they just covered everything. They were just marvellous. Anything you needed to know...you were sort of bombarded with everything. You couldn't take everything in but they kept saying: "don't worry, keep asking". And everything I thought of I wrote down because you just can't take it all in" (13.2).

In being a nurse, of course, this mother already had a knowledge-base against which to set the information she was receiving. Another mother of a diabetic child said that to her the leaflets were not good and that she was "...better off actually dealing with it". In other words, parents often felt the need to be learning by doing, and in this process the presence of someone to ask questions to, whether a nurse or a dietician, was crucial. Information alone was of little use without the existence of a guide or interpreter to help them make the information their own. Similarly, a mother of a child with cystic fibrosis (CF) spoke warmly of the support she had received from doctors, nurses, counsellors, psychologists, physiotherapists, dieticians, and social workers. In this situation, the

multiple needs of her son were responded to in a rational and co-ordinated way by a variety of trained helpers who provided her with a range of different kinds of information to enable her to care for her son. Such technical information and advice was provided not only for problems in dealing with physical problems but a variety of other difficulties as well. For example, the CF nurse was a constant source of information on a range of issues to do with care, while the social worker gave advice on social security benefits, the psychologists gave her advice on how to cope with bullying at school, and the physiotherapist taught her techniques to help her son breathe.

These situations were models of good practice and helpful collaboration between individual professionals with particular areas of expertise, and a parent who has somehow to integrate them within an overall programme of care.

Where the condition is less clearly defined, where the needs a less clear-cut, and where there is no codified body of knowledge to transmit, the needs for information are less easily met. A mother whose son had a congenital digestive disorder said of the nursing care she had received from community nurses:

> "Some of them are very nice and some of them just haven't got a clue what to do or how you feel" (1.6).

Another mother of a child with thalassaemia said that a health visitor used to come to her home but that she was "unable to answer any questions", and just used to say "I don"t know". She felt that she would only want help from a nurse if the person was able to answer the questions she asked.

The nature of the information needs in many of these situations is complex, not only because a condition is difficult, but because the professional providing the information has to be able to perceive what is required when there are no simple technical solutions to be offered. The mother of a child with an undescended testicle and a variety of other unrelated health problems said that the problem for her was not that she wanted or needed specific technical information and advice, but that she did not know what it was she needed. As she put it:

> "I think [its a question of] finding out what care you do need if you need anything [...]. You do need someone to say: "do you need any help", or even to notice that you might need help, you know" (2.11-12).

In other words, parents often do not know what information or advice might meet their needs because they are not sure what those needs are.

Parents thus came to see that information was not a set of

clear-cut instructions. Even where the condition was located within a clearly defined body of knowledge, as with diabetes, the process of making use of that knowledge in everyday life was often difficult and uncertain. Moreover, parents often had to move from assuming that all health professionals were part of the same world, to recognising that they might have to expect contradictory advice from different professionals. As one mother told us:

> "We'd got problems with a doctor telling me one thing, a nurse telling me another thing, and [the consultant] saying "no I didn't say any of that at all" (2.4)

In talking about information, therefore, it became clear from our data that the difficulties involved in information transfer could not be understood separately from other aspects of the relationships between parents, nurses and other human resources. For example, one mother indicated the generic need for 'advice' when she said: "I get the advice that I want off my health visitor, or the hospital, or my doctor". What was important very often was good communication rather than specific items of information.

The need for communication

The need for information was part of a wider need for open and regular communication. Parents valued communication between professionals and themselves. They wanted to be

told what was happening to their child and what they could expect. They were prepared to recognise that some areas of knowledge are difficult, but expected doctors and nurses to make efforts to translate from technical to lay vocabulary. Nurses who exhibited willingness and skill in this were highly praised. However, it also emerged strongly that parents did not expect to be given all the answers. Many said they respected those professionals who told them: "I don't know"; and in such situations they welcomed professionals sitting down with them to discuss what both parties might do to find out.

One mother whose child had a congenital digestive disorder spoke highly of the paediatric nurses in training at the hospital. She said: "They would show a lot of affection towards him (her son)[...]. They listened to what I said whereas some of those [general hospital nurses] would dismiss me, you know, saying "she's not qualified" (1.9). We have already indicated that from the parents' point of view it sometimes did not matter that a community nurse did not know the answers to all the questions they had. As the mother who had to deal with her son's tracheostomy told us:

> "[The health visitor] is quite good. If you have any problem and she is not so sure, instead of just advising me she'll come down, she'll sit and talk to me, she's quite good" (6.3).

A respondent whose son had been in hospital with swollen testicles said that the nurses in the hospital had been "smashing", but that once they got home things were less satisfactory:

> "The health visitor came when my son came home[...] but she didn't seem to know...she seemed as if she didn't know a lot about children...She wasn't used to dealing with children [...]. She didn't even seem to talk to him, she talked to him like he was an adult. She didn't know what he'd had done [...]. I thought at the time it would be really nice to have a children's district nurse" (8.3)

The issue of communication had wider connotations than skills in one-to-one or one-to-two relationships. For example, the mother of a child with spina bifida found the specialist nurse from the hospital, under whose care her son remained, helpful in easing communication in other ways. In addition to coming to their home to talk them through an operation beforehand, the nurse played a role which the mother described as 'friend', but which included the roles of mediator, facilitator, and translator:

> "My son thinks of her as our friend, and its nice, and I like it like that [...]. And its nice because you can ring up and have a chat with her and she can advise you, not like a nurse of a Sister, you know.

It's great, it must be a new thing ... I've never come across it before" (3.11).

In situations of complex chronic disease, however, the need is often for communication with a whole system rather than a particular individual, and this system contains languages which, intentionally or otherwise, can limit communication. The same mother went on:

> "I look after handicapped children, I can do anything with them, but I can't talk nice and I don't know these medical words. When I go to the hospital, I don't know how to word it [to the consultant]. I don't know the word and [the nurse] will do, and I feel I get to know more because she will interpret it for me" (3.11).

One mother whose son had problems with his eyes said of her experience of seeing the consultant that "...we're sort of not equals in the conversation [...]. It would have been a lot nicer if they had included us in the conversation" (8.16). In these situations the role of the nurse in communication becomes even more significant.

There were a number of different components, therefore, to what we have referred to as the need for communication. Parents valued good communication between themselves and the nurses who cared for their children; they valued

openness and friendliness between the nurses and the children themselves; and where the child was under the care of the hospital consultant, parents appreciated the role that some nurses were able to play in mediating between their own concerns and those of the medical staff in the hospital.

The need for support

Support is difficult to define. Indeed, the need for support was really the most general kind of need. This makes it difficult to decide whose responsibility it is, and how to provide it. Very often it is assumed that some kind of community or network exists within which support will be automatically warm and forthcoming. However, what has emerged clearly from the data is that parents value displays of affection from nurses to children, and reassurance from nurses to parents. For parents of children with chronic health problems these were ongoing needs, for those children with an acute problem there was an intense need for general support in the days and weeks following discharge.

Although support included the information and communication we have already spoken of, its defining characteristic is really summed up in the phrase 'being there'. As it stands this could sound like a rather romantic idea of no real importance in the material reality of modern health care.

However, for many of these parents the provision of support in this sense was vital to the physical and mental health of themselves and their child. In addition to the need for help being provided, parents, particularly of those children subject to periodic crises in their health status, strongly valued the willingness of both hospital and community nursing staff to be 'accessible'. This meant that parents wanted to be able to feel they could phone the hospital without fear of rejection. More specifically, it meant professionals' willingness to provide people with telephone numbers where they could be contacted day and night.

Sometimes the need was simply for little items of information necessary to deal with some kind of caring task. However, as we have seen, the need is rarely just for information. As the mother of the boy with spina bifida put it:

> "She's talked to us, she gave us her 'phone number at home and at the hospital, and if ever there is a problem I can phone her and she will come, or she will arrange what should be done next" (3.10).

Another mother of a child with a tracheostomy used the health visitor in a similar way:

> "She gave me her work telephone number and also her

home telephone number so that if I needed to know anything I could always phone her at home, or if I was worried about anything I could phone her at home, which I have done a few times" (6.3).

This quality of being available was closely related to what we referred to in the last section as friendship. However, the quality that the parents valued as support was more than just acting like a friend, it meant being available to act on the parents' behalf at any time. However, being given someone's home telephone number was clearly seen as an important symbol of a special kind of relationship that transcended the obligations of professional care. Parents of children with chronic diseases subject to periodic crises, such as diabetes, came to value the support not just of a particular role, but of a particular individual in a role.

One mother said the diabetic nurse was "brilliant", and that she was "a friend as well as a professional" helping to cope not just with the problems associated with the care of the child, but other coincidental problems in living that affected her ability to cope. Although she had learned to cope with many aspects of her son's diabetes, she was aware that her son was desperately afraid of having to go into hospital. In this situation she felt that she was unable to offer him the support he needed:

> "He's frightened of being admitted to hospital, but [the diabetic nurse] is trying to reassure him that, you know, unless he is absolutely ... she's told him that as long as I can cope with it he won't have to go in" (13.8).

What made the role played by the diabetic nurse so supportive was not only that she had knowledge and skills which reassured the mother, but also that she made use of them in a way that supported rather than supplanted the mother. The role is almost one of being professional in disguising certain aspects of professional identity: "She's so approachable, and at the end of the day she's an ordinary mum like me you see" (13.20).

The need for advocacy and linkworking

A major problem for parents with sick children is the multiple agencies with which they are often required to deal over the short- or long-term. As a recent report (February 1993) on caring for sick children has indicated there is often a need for 'bridging the gaps' that emerge at the interface of health (hospital, primary, and community), social, and educational services. The gaps are often an absence of some kind of service, or an inappropriate service that undermines the parents in what is, as we have said, a moral as well as a technical role.

Our research showed that this activity of representing to a third party a demand or need that the parent felt unable to express was crucial. For example, the mother of a diabetic teenager said that "... there was one teacher [who] said "I'm frightened of having your son in my class" (13.16). She spoke about this to the diabetic nurse who offered to go and see the teacher for her.

Community nurses also could play this kind of role. One mother was having problems getting her son into a nursery because he required special feeds and wore nappies. Since the instigation of local management of schools there is no 'higher court' for people to appeal to - other than the Secretary of State. In this context the health visitor was playing an important, though perhaps hopeless, role, helping the mother organise appropriate education for a child she thought of as "...having nothing wrong with him mentally or physically" (1.13). The interface between home and school was very important for mothers with young children, and they often relied on nurse for help in negotiating these barriers. It is often seen to be a crucial and determining moment in their child's life, and they recognised that labels applied at this time might be very difficult to remove later on.

For mothers of children with a digestive disorder or tracheostomy, community nurses often acted on behalf of the parents in situations in which there was a problem in getting hold of supplies necessary for the technical

management of their child's condition. Supplies of tube for managing a tracheostomy, for example, or explaining to the GP why such large supplies of clean needles were necessary for a mother of a diabetic child. In other situations, as we have seen, the nurse plays a crucial role in linking the parents to the consultant. This is partly covered in what we have said about translation and communication. However, there were situations in which a nurse had to represent the interests of the parents to medical staff in a style more similar to advocacy. Situations were described in which parents did not feel powerful or knowledgeable enough to speak to the consultant, and nurses played an important role in this.

The need for respect

Underlying all these specific areas of need is something rather less easy to describe. It relates to how people are seen by professionals. It has often been pointed out that even where the welfare state is working efficiently and effectively there is still a tendency for recipients of care and support to be made to feel unworthy. The notion, originating in the Poor Law reforms of the last century, of the deserving and undeserving poor is the best known illustration of this, and it is often used by politicians as a way of making those who are in need feel unworthy. As one commentator as rather elegantly expressed it: "Needs are met, but souls are dishonoured".

Medicine and health care are usually seen as one component of the welfare state which is unequivocally good. Provision relating to the health of the nation is regarded, almost by definition, as deserving. However, in recent times we have seen political and economic forces undermine this previously robust assumption. Why should someone who has smoked cigarettes all his life and, against medical advice, continues to do so be seen as deserving of cardiac surgery as someone who has lived a 'blameless' life? Why should young women who 'fail' to follow advice about contraceptives be supported by the State? In other words, the moral debate about illness and treatment, fuelled by governmental anxieties about public expenditure, has made the right to health care much less clear-cut than it once was.

Living with illness and the delivery of health care are moral as well as technical concerns; and they are influenced by wider changes in politics and the economy. Throughout these interviews it became clear that the relationships, or lack of them, between the mothers, their children, the nurses, and other health care workers. Friendship, openness of communication, and support in knowing that you are doing the right thing are at least as important to the parents we have spoken to as technical competence. Moreover, parents, particularly mothers, looking after sick children develop a vast amount of knowledge about their child's condition, and the

complexities of the health care system. While the nurse or the doctor may feel that she or he is the 'key worker' in relation to a parent and child, the parents are quite likely to have a much more pragmatic and catholic approach to the matter. Very often they know what is needed and what is required from the health care system is someone to act as the legitimate gatekeeper to a range of resources.

All too often in these interviews we heard of situations in which parents felt that they had not been shown proper respect. This sense of disrespect came across not only in the rudeness and arrogance displayed by some nurses and some doctors, but in the small ways in which parental competence in dealing with difficult caring activities were undermined.

This moral need for respect involved expectations of honesty, and a willingness to attempt to see needs from the parents' and the child's point of view. This means that professionals need to recognise that these parents often have their own expertise, but even where expertise is lacking, parents wanted to be understood as people who were desperately trying to do the right thing in often difficult circumstances. One woman caring for a diabetic child had felt devastated by the consultant's suggestion that her teenage son was 'cheating on his diet":

"The consultant hinted that he thought [my son] was

cheating on his diet. Well, I came home from hospital absolutely devastated because he isn't. The [diabetic nurse was away at the time, which didn't help, because the first thing I would have done would be to ring [her] and she would have come and had a chat with me. But it hurt me because I know that he's not [cheating on his diet], because he doesn't have anything that he's not to have. He's marvellous with his diet" (13.10).

Another woman looking after a child with a complicated digestive disorder said that some of the nurses would dismiss what she said, and that some of them had actually said to her: "You haven't trained for three years".

It may be thought, in the first example anyway, that the mother had taken it the wrong way. We would argue that the consultant should have been sensitive and thoughtful enough to have seen the effect his statement might have had. It is important to recognise that parents do develop a large body of knowledge. The issue of 'respect', therefore, is not to be confused with being polite and kind. Of course these are important, and not all health care workers are able to be like that. However, we are talking about something rather more than that. The data show that parents value having their views heard, and their opinions given equal weight in the development of treatment programmes for their children. After all, they are truly

the 'key workers'.

The kind of knowledge parents develop is, of course, experiential and subjective. It is not based upon a detailed reading of anatomy, physiology and pathology textbooks. It's foundation is not years of training in hospitals, and working with doctors. It <u>is</u> based upon experiential knowledge of a child's illness in the setting of the community. While it is true to say that the application of knowledge may be impaired by anxiety of fatigue, our data do not give the impression of parents who are unable to deal with the heavy routine demands of patient management. What the data do show is that parents learn to cope, but that this process of coping is helped enormously by the intervention of support and advice from a range of professional skills in a manner which supports rather than undermines the parents' own strategies. If the movement of nursing from hospitals to communities is going to become real community health care it must involve a genuine attempt to break down the separation of 'experts' and 'lay people', and 'professionals' and 'patients'.

<u>Conclusion: The skills required to nurse sick children in the community</u>

The forms of help identified from our research match, to a large extent, the four distinct domains identified by Sheila Twinn (1991) in her study of conflicting paradigms

in health visiting. The four domains identified in her research were: individual advice-giving; psychological development; emancipatory care; and environmental control. In the case of sick children however there is also the important dimension of technical skill.

1. **Technical skills**. Parents value health care workers who know what they are doing. The relationship with families is fragile because it will be continually tested by the problems that arise. In the early, fragile, stages of a relationship the primary emphasis will be on the technical aspects of care. There needs therefore to be a high level of skill and confidence if the trusting relationship is to be maintained. This health care knowledge includes a willingness on the part of professionals to admit to the parents that they do not know what they are doing, and this in turn requires a high degree of confidence in the health care professional.

2. **Practical help** (including respite care). Parents inevitably sometimes find themselves stretched to the limit by competing priorities which are difficult to organize. They need health care which includes people who can come in and 'take over' the doing of certain tasks which the parent feels they just cannot do at that moment. This again, implies, that, for sick children, there are the necessary skills and ability to deal with these sorts of demands.

3. **Networking and advocacy.** The health and social care systems are enormously complex. Very often parents know what they want but do not know how to go about getting it. They need people who can access the system for them and deal with any barriers that are put in their way. Because these networks are complex and subject to change that, at times like the present, can be rapid, this implies that the nurse has a high level of experience and familiarity with the community structures and the confidence to deal with them.

4. **Interpersonal and psychological support.** Dealing with a child who is ill can be heart-breaking. Parents are often overcome by emotions that they cannot control and which are perfectly understandable once you try and understand them. Part of the knowledge required of health professionals is what the German sociologist Max Weber referred to as 'verstehen'. This empathy or intuition is not something that everyone can do. Nor is it easier or inferior to more technical aspects of care. It is a form of knowledge in action which is indispensable to good health care whether in the community or the hospital. And, of course, as Benner (1984) has pointed out, these qualities can be seen as representative of expert practice.

The needs expressed by the parents in our study, imply the need for a flexible form of working determined by changing health needs rather than by the detailed job description of

the particular professional. Clearly, some of the needs expressed by our respondents relate to highly specialised skills. However, it is also apparent that other kinds of knowledge and skills are also valued. There is substantial interaction between the technical and the non-technical skills, the emphasis on each one being dependent on the sort of illness the child has and the stage of that illness. Working in the community therefore, whether by hospital-based or community-based nurses, means being able to work flexibly, in participation with patients, across a range of domains relevant to individually expressed needs and with a high level of expertise.

Within this context of the perceived needs of families with children who have a variety of illnesses and health care needs the data on the education and training of paediatric nurses to work in the community will be presented. There are two sources of this data, the survey of colleges and the in-depth interviews of teachers, students and mentors at four colleges. The latter is generally used to clarify and develop the survey data.

The Educational Preparation of Sick Children's Nurses

The findings from the survey of the colleges of nursing and the in-depth studies of the four centres will be presented in the following sections:

1. The community experience of college staff delivering the Child Branch.
2. The community placements for students
3. The length and type of community experience
4. The services perceived by the course leaders to exist in the community
5. The relationship between the Common Foundation Programme and the Child Branch community experiences.
6. The nature of the clinical supervision that the students have in the community
7. The assessment of the practical competence of the students in the community
8. The philosophies of the courses
9. The links between educationalists and the community staff
10. The difficulties in organising placements
11. The Child Branch diplomate in the community
12. The nature of the learning experience

The Community Experience of the College Staff

An initial question that needs answering before looking at the Child Branch structure is whether there is contiguity between the training and experience of the tutorial staff in the colleges and the aims of a P2000 Child Branch. The data reported in Table 3 represent those backgrounds reported for each college. It can be seen that approximately a quarter of all colleges that have started

or are waiting to start the Child Branch are proposing to deliver the curriculum using staff with no community experience. Furthermore, the community experience of staff in those colleges reporting some experience is generally Health Visiting. Only two colleges reported having staff with experience as Paediatric Community Nurses. The data does not show the proportion of staff in each college with community experience. This data therefore shows that 16 colleges who have started the programme have at least 1 Health Visitor on the teaching team, and so it presents a picture of the minimum experience available on the team.

TABLE 3. The Reported Community Experience of Child Branch College Staff

	CHILD BRANCH PROGRAMME	
	STARTED	NOT STARTED
HEALTH VISITOR	16 (70%)	5 (42%)
NONE	5 (22%)	4 (33%)
SCHOOL NURSE	3 (13%)	1 (8%)
PCN	1 (4%)	1 (8%)
DISTRICT NURSE	5 (22%)	1 (8%)
LEARNING DIFFICULTIES	0	1 (8%)

The Community Placements of Students

The pattern of community placements for students on the Child Branch was found to be complex. In some colleges, for example, the students could be exposed to placements in as many as 11 different settings, in others only 1

settings. The reasons for this are related to several factors: the philosophy underpinning the course; the concept of 'community' that is used in this philosophy; the pragmatics of organising placements, and the availability of certain community services in the colleges' operational area.

One way of clarifying this issue in terms of the Child Branch is to use the concept of the **core** community experience. Core experience means, here, the main experience that the students have in their specialism in terms of **time**. If a student has, for example, a community placement of 10 weeks and the longest period in any area to do with children is 3 weeks then that will be described as the core experience.

Using this idea of core experience has a central assumption. This is that not all community experiences are of equal value to students undertaking a branch programme. In other words colleges will prioritise placements and the most important in educational terms will be given the longest period of time. So it could be assumed that for a student in the child branch that community experience with sick children is important for a student in the child branch. These might seem rather obvious assumptions but it will be seen both in this section and in later sections of this study that these are not necessarily commonly held.

The core experience, so defined, for students in the Child Branch programme is given in Table 4 below.

TABLE 4. Core Community Experience of Child Branch students

BRANCH PROGRAMME	TYPE OF COMMUNITY EXPERIENCE (No. of colleges)			
	PCN	HEALTH VISITOR	OTHER*	TOTALS
STARTED**	6	16	3	25
NOT STARTED	2	3	5	10

* Special Schools/Special Needs/college unable to specify because either they had very fluid placements or were still negotiating them.

** Started= students were actually on the Child Branch course. Not started= the Child Branch was validated and students were on the Common Foundation Programme and booked to go on the Child Branch.

TABLE 5. Length of Core Community Experience

CORE EXPERIENCE	MEDIAN (weeks)*	RANGE
HEALTH VISITOR	5	1.2-21
PCN	3	1-5
OTHER	2	0-6

* week = 5 days

Three models of community experience for Child Branch students can be suggested from this data. The first where the core experience is with PCN's, the second where it is with Health Visitors and the third, which could be called the pragmatic model is relatively undetermined.

From the above it can be seen that the main core experience that is offered for Child Branch students on a national basis is with Health Visitors. This is a main experience in terms of both the number of colleges that use it and the length of that experience: more colleges use the Health Visitors and for longer than any other sort of core experience. However, this generalisation has to be qualified in terms of the range of possible core experiences. When we look at the range of possible placements we can see that for the Health Visitor the placements can extend in length from 1.2 to 21 weeks. In other words there is little uniformity in the length of the core community experience.

The Length of Child Branch Community Experiences

Of course, the core experiences do not constitute the whole of most college's provision for their students. Looking at Table 5 we can see the range of total lengths of the experiences varies around a median of 7 weeks. The median is higher for colleges who have not yet started. This could be a result of the sample or could be perhaps a reflection of the practical difficulties in organising placements that face colleges whose programme is up and running.

TABLE 6. The Median Length of Child Branch Community Experiences

	STARTED	NOT STARTED*
RANGE (weeks)	2-15	5-21
MEDIAN	7	10.5

* 3 colleges data missing because the placement lengths were still under negotiation

There is an obvious discrepancy between the above data and the median figures given for the length of the core experience. The difference is made up in a variety of placements. From Table 4 it can be seen that there is a wide variety of placements used with varying frequency.

TABLE 7. The Frequency of Use of Placements other than the Core Placements

	BRANCH PROGRAMME (No. of Colleges)	
	STARTED	NOT STARTED
SCHOOL NURSE	13	5
SCHOOLS	12	3
NURSERIES	6	1
SPECIAL NEEDS	8	3
LEARNING DIFFICULTIES	6	1
RESPITE CARE	3	1
BEHAVIOURAL PROBLEMS	2	1
POLICE COURTS	2	1
MIDWIFE	3	1

There were a number of placements reportedly used by only one college and so not included in the table above. These were, for example, Brownies, Speech Therapy, Physiotherapy, Family Centre, Rehabilitation Unit, Hospice, Swimming Club, Riding Club, Playgroup and Psychiatry.

The Health Visitor Model

The Health Visitor's practice is, of course, almost exclusively from a health base and they have significant involvements with caring for families. The type of experience of the community which can be offered to the student from this model was described by one health visitor as:

> "... an overall view of the Health Visitor Role, how they link in with all the health promotion clinics, family planning clinics, post natal clinics ... They do spend time with the School Nurse within that time out in the community. We also try with the Child Branch specifically if District Nurses do have children in their case load that they do spend some time with the District Nurse, so that they can see the family as a whole rather than just looking at the child. So they spend some time with each of the Primary Health Care Team" (Centre 3: Mentor).

The skills which the student will observe the Health Visitor using are described as:

"Health Visitors see their skills in being working with families, working with parents, not just with children and tasks ... hopefully the kind of practitioner that we are aiming for as well, not somebody who just cares for the baby in the cot ... and I think there's more in common than many people actually realise" (Centre 1: Teacher).

The Health Visitor within this model is responsible for the student's community experience and is also responsible for mentoring, supervising and assessing the student. The experience offered by the Health Visitor is seen as being valuable but the major concern continues to be that their practice is limited to health and therefore not totally relevant to the children's nurse:

"The Health Visitors will largely claim that they are looking at health and doing their statutory duty. Largely, I think, that they claim that they're not there to look after sick children in the community and yet it is really only the health visitor that we can send the students out with, so they're looking at a valuable part of assessing and normality and what do you do if you find someone isn't functioning normally, who do they get referred onto. There seems to be something very valuable there but paediatric nursing in the community has got to be something more than that" (Centre 1: Teacher).

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It appears from the interviews with the tutors in the centres with the Health Visitor model that, generally, Health Visitors have been given a role because in many areas they are the only community practitioners who are able to provide any relevant community experiences for the children's nurse.

> "Some of the Health Visitors are quite happy having them (students) most of the time, that's because they are heavily committed to teaching. There are others who perhaps working a different way and haven't had students find them a bit of a strain" (Centre 3: Mentor).

The main issue of the relevance of the Health Visitor models seemed to be the absence from the Health Visitors practice of regular contact with children who are ill:

> "Occasionally there are sick children on the Health Visitors case load" (Centre 1: Mentor).

A Paediatric Community Nurse who was interviewed strongly questioned the relevance of the community experience:

> "All the relationships with the family change and you need to be aware of that and its so much different from having a well child in the family, and I feel everything totally changes, everything, and you need to have sort of insight into that" (Centre 2: Mentor).

Strong views are held on whether the Health Visitors were the appropriate practitioners to be taking such a leading role with the students. Another Paediatric Community Nurse said:

> "The very significant majority of Health Visitors in this country have completed less than 12 weeks experience (with sick children) in the totality of their career. They may have considerable experience in the normal development of children, in child health but they have little experience in the care of sick children as a rule" (Centre 4: Mentor).

The Student Views of the Experience with Health Visitors

Students who have undertaken community experiences with Health Visitors present a mixed picture of the value of their experience. Some recognise the positive features:

> "I had a really good time, but I think it depends who you go with and what area you're in, what the workloads like you know and the attitude of your health visitor is" (Centre 3: Student).

> "It was really good ... you see how other people live, you know you see behind the closed doors that normally you wouldn't. The conditions that they live in and

the facilities that are available and financial help, they do or don't get. You know, how they actually have to live and bring up a child in that environment" (Centre 3: Student).

Others emphasise some of the negative features:

"You don't build up a relationship with the clients and you invariably see well children which is all good and well but we never did any actual nursing as such, nursing sick children in the community" (Centre 1: Student).

"You can't retain any of the information that you're given, in community you're doing visits, you meet a family, its such a short placement and you never see the family again. So you never actually see the follow up so although you can understand, you can observe the relationship the health Visitor had, its difficult to see yourself because you never got into the same family more than once. So its like seeing a lot of new faces all the time" (Centre 1: Student).

These comments emphasise the two main areas of concern, the first being the student's ability to see the Health Visitor's practice as being relevant to them; and secondly, the relatively short length of time which the student spends in the community.

The Paediatric Community Nurse Model

The second model which is used to provide children's nurses with community experience can be described as the Paediatric Community Nurse (PCN) Model. It was seen from the survey that this model is in the minority and that there is a relative paucity of PCN services compared to Health Visiting. As one PCN said:

> "In total, in the United Kingdom somewhere in the region of 150 Paediatric Community Nurses who are general PCN's and then there are about 80-90 specialist Paediatric Community Nurses" (Centre 4: Mentor).

The Services contain only low numbers of nurses and as such have only a limited ability to offer placements for students.

> "In Paediatric Community Nursing Services you are looking at teams in general no bigger than 3 or 4 nurses" (Centre 4: Mentor).

Because of these reasons placements are heavily in demand from both the Common Foundation Programme and the Child Branch and therefore offers of placements tend to be for very short periods of time, 2-4 weeks in the Centres which were studied. This can lead to the problem where:

"I personally don't believe it actually educates them enough in community paediatrics in particular, to actually work in that field without further experience post training" (Centre 4: Mentor).

The role that is undertaken by the Paediatric Community Nurses was identified within one of the Centres studied as:

"We have a case load here of about 200 children with chronic health deficits, children with diabetes, children with asthma, children with cancer, cystic fibrosis, children with congenital defects, children with neuro-developmental problems and then we have sort of a rolling case load of acute children... ...those children will need relatively intensive bursts of nursing to deal with an acute health deficit" (Centre 4: Mentor).

Students in the four centres recognised the Paediatric Community Nurse as a powerful role model but were very concerned at the short period of time which they spend with them. They recognised the value of the placements in demonstrating that relatively ill children could be cared for in the community, an issue not always recognised within the hospital. One student explained:

"A lot of the staff don't realise what can be done at home and if they had been out with them like we have they would have realised that a lot of children could be referred home say a day earlier... ... I've used the knowledge that I learned in the, out in community, I've used it in the hospital more" (Centre 4: Student).

Hospital based Paediatric Clinical Specialist Nurses, often referred to as Outreach Nurses, provide care for children within the community in relation to their designated area of specialism. Due to their possession of high levels of technical skill and experience they are powerful role models. With regards to their involvement with students it appears to be opportunistic in nature rather than being part of a planned programme of experience. Therefore, the amount of experience which students undertake is minimal and varies considerably from student to student. This type of experience is usually undertaken in units of single days or even parts of one day.

The Pragmatic Model

There are a number of other significant practitioners whose contribution to the children's nurses initial preparation became apparent. Although they were used in conjunction with PCNs and Health Visitors there was also a group of colleges who relied on them for placements.

The District Nurse is recognised as a source of potential community nursing experience with children although they are stated to have only a minimal number of ill children on their case loads. One teacher estimated that children will not take up more than 5% of the District Nurse's caseload. Another Mentor reported that they would attempt to arrange for students to have experience with the District Nurse so that, "... if District Nurses do have children on the case load they do spend time with the District Nurse" (Centre 3: Mentor).

This process of arranging experience appears to be difficult and the majority of students interviewed reported either minimal or no visits undertaken with the District Nurse. A teacher presents a possible explanation for why this may be the situation;

> "District Nurses are quite often very concerned about going into the home of a sick child because they accept their own inadequacies of knowledge and skills" (Centre 2: Teacher).

This issue was also highlighted by a Community Paediatric Nurse who reported on efforts to improve their Service's relationship with local District Nurses where "... some of the District Nurse were very negative about us, very threatened" (Centre 4: Mentor).

It must be significant that the role of School Nurse did not emerge from the data as being important in terms of providing the students with experience of children within the community, although the survey indicated that at a number of centres they contribute towards the student experience. From the information available it is impossible to identify the nature of its significance.

Community Services Perceived to Exist in the Area

The sorts of community services that exist in an area will obviously have a substantial impact on the range of possible experiences in the Child Branch. This section examines the perceptions the leader of the Child Branch have about which community experiences exist in an area rather than the objective question about which services exist in fact. This is useful for two reasons. The first is that it gives an indication of the congruence between the services used and those that are seen to exist. The second is that it gives some indication of the possible problems that might exist in organising clinical placements. There is the problem, of course, that the information given is inaccurate because of the problems of memory recall, changing services, the course leader being new in the post and so on and so forth. This data should therefore be seen as exploratory and, perhaps, a useful source of illumination rather than definitive.

It could be that the reason that the Health visitor is seen as the core placement is because of the relative unavailability of community paediatric services. If we look at Table 8 we can see that in neither case was there a statistically significant difference between the core groups in terms of the availability of the services. However 60% of colleges report the availability of some hospital based PCN service, and 40% report a community based service. If we look at the availability of Health Visiting however in Table 10 we can see that 94% of colleges report a Health visitor service being available.

TABLE 8. The Number of Colleges Reporting the Availability of Hospital based PCN services

CORE PLACEMENT	NO PCNH*	PCNH	TOTAL
PCN	2	6	8 (23%)
HEALTH VISITOR	9	10	19 (54%)
OTHER	3	5	8 (23%)
TOTALS	15 (43%)	21 (57%)	35

* Hospital based PCN

TABLE 9. The Number of Colleges Reporting the Availability of Community based PCN services

CORE PLACEMENT	NO PCNC*	PCNC	TOTAL
PCN	5	3	8 (23%)
HEALTH VISITOR	15	4	19 (54%)
OTHER	5	3	8 (23%)
TOTALS	25 (71%)	10 (29%)	35

* Community based PCN

TABLE 10. The Number of Colleges Reporting the Availability of Health Visiting Services

CORE PLACEMENT	No Health Visiting	Health Visiting	TOTAL
PCN	0	8	8 (23%)
HEALTH VISITOR	0	19	19 (54%)
OTHER	2	6	8 (23%)
TOTALS	2 (6%)	33 (94%)	35

There were no statistically significant differences seen between colleges that had started the Child Branch programme and those that hadn't in terms of the availability of PCNs, either hospital or community based, and health visitor services.

It appears then that while there is clearly a difference in the relative frequency of the availability of Health Visiting and PCN services, this data does not explain why some colleges use the PCN core experience rather than others. It could be, of course, that it is the relative number of PCN nurses available that makes the difference, however, when we combine this data with that resulting from the analysis of the philosophies, it could be argued that this imbalance is also a result of the emphasis on dealing with health rather than sickness in the community.

The Relationship between the Common Foundation Programme and the Child Branch

It could be argued that the whole of the P2000 course content should be considered, rather than just the Child Branch community experience. This argument rests on two assumptions: the first is that the student needs to develop an understanding of health, and second that this understanding can result from a variety of experiences that are not necessarily related to the sort of Branch programme that they will undertake. It is interesting to look at the type, and length, of experiences that relate to children in the Common Foundation Programme. This will give some indication of the possible qualifications to the data presented above about the Child Branch experiences.

The Type of Experience in the Common Foundation Programme

The type of experience in the Common Foundation Programme is mixed, and the mixture varies from college to college. Included are health visitors, midwives, special schools and ordinary schools, as well as community groups of various sorts. Although the data is complex 13 colleges report Health Visiting as an important part of the experience. Looking at Table 10 it can be seen that the median experience is 11 days with children although the range of experience differs substantially both within those colleges that have started the Child Branch, and between them and the colleges that have not yet started.

TABLE 11. The Length of Community Experiences with Children in the Common Foundation Programme

CHILD BRANCH	MEDIAN (days)	RANGE (days)
STARTED	11	0-30
NOT STARTED	11	4-95

Project 2000 Philosophy And The Course Structure

A category which emerged with some strength in the focused interviews, particularly those with teachers and students was in relation to the philosophy of Project 2000 and the structure of the course.

It appears to be the perception of students, most strongly, but also of teachers, that the Common Foundation Programme and Child Health Branch Programme are separate courses. Experiences undertaken in the Common Foundation Programme, both theoretically and practically, are not directly relevant or focused to the needs of the students undertaking the Child Health Branch:

> "How can I say this? I think that the student who come to us with a vast amount of knowledge. The problem I think some of them have is in comprehending and applying that knowledge to children because its come through in a very generic foundation and although

we have , you know, we try to put the emphasis on all four branches within that I'm not sure that does necessarily happen" (Centre 3: Teacher).

This response emphasises the problems created by the generic nature of the Common Foundation Programme but is also indicative of another issue which also affects teachers of children nursing, that because they are few they have difficulty making a major contribution into the Common Foundation Programme and therefore compound the lack of emphasis on the children's nursing focus. This phenomenon is also reported to affect the Mental Health and Learning Disability Branches in a similar way. The centres followed a similar pattern of including within the Common Foundation Programme approximately four weeks experience in the various nursing specialities and the rest of the experiences related primarily to adult nursing. This was confirmed by the comments of some students, for example:

"The Common Foundation Programme, its very much biased on adult nursing, most of the emphasis, the lectures. I mean that's fair enough because the majority of them are 'adults' but there was very little emphasis on the child and the family" (Centre 4: Student).

"The philosophy of Project 2000 is that it is one course but it doesn't feel like that" (Centre 4: Student).

The focus of the Common Foundation Programme tends to be on Adult Nursing as do the majority of practical experiences that students receive. The community experiences, in particular, within the Common Foundation Programme are rarely focused on children and it is therefore the perception of many of the students interviewed that they only really start learning about children's nursing when the Branch programme begins, and that they are then disadvantaged because they are attempting to develop competencies within only an 18 month period rather than the 3 years of the course. This presents an interesting comparison with the preparation which was used in the past through the 18 month post-registration RGN route.

Students also emphasise how the quality of the course has been enhanced since they moved into the Branch. The following is a typical comment which suggests that learning within the Common Foundation Programme tends to be problematic:

> "The lectures are twenty times better ... the quality of information and the ease of which it is presented is a lot better ... I think everyone was really keen to get out of the Common Foundation Programme" (Centre 1: Student).

Some students commented on the great potential which the Common Foundation Programme has but which is not maximised:

"But the potential though is there, you just don't seem to follow it through though, it just amazes me!" (Centre 3: Student).

Another student took this important issue further:

"They don't build on it. They could strengthen it so much by just adding a couple more blocks, more paediatric orientated" (Centre 1: Student).

Some students at all centres were critical of the Common Foundation Programme providing the following comments:

"When we came to the Child Branch we were so adult orientated we didn't really have a clue about children" (Centre 3: Student).

"I just felt like I knew nothing and was starting a new course" (Centre 1: Student).

The Common Foundation Programme does not seem to be providing the type of common experiences which it was intended to do. It should provide a balanced experience of all the four main branches of nursing as a sound base from which the nurse can develop his or her career. It should also provide a strong theoretical base from which the student can explore issues relevant to the branch of nursing in which they wish to practice. The 'common'

elements appear to be dominated by adult nursing whose teachers will be providing the majority of the teaching input. In the community experience the concept of community is either implemented so widely that it does not relate at all to children or students are placed with community practitioners who have little contact with children. The students' comments indicate that they are being frustrated by the Common Foundation Programme seeming distant from their area of interest.

The Common Foundation Programme was accepted by the profession on the understanding that it would relate to those areas that are 'common' to all branches of nursing, not to be biased towards any particular branch. Each branch could give strong reasons why they should receive more of the Common Foundation Programme but it would appear that in the present situation it does not relate to this but, rather, to weight of numbers.

This data suggests that the Common Foundation Programme needs reviewing to ensure that it is educationally viable and to ensure that it is not just the result of pragmatic solutions to resource problems.

The nature of the clinical supervision that students have in the community

The character of the supervision will be, presumably, an

important element of the community experience for the Child Branch students. The supervision will partly determine the quality of the experience and also its relevance to the community role of the paediatric nurse. It is interesting therefore to see that for the colleges who replied to the survey there is considerable variation in the variety and type of supervision offered to the student. However, the key professional used as clinical supervisor is again the Health Visitor which is mentioned over three times more frequently than the PCN for those colleges that have started the branch programme.

The perception of what defines a clinical supervisor differs between colleges. For some the clinical supervisor is the community nurse with whom the student is placed, and for others it is the college tutor who supervises the student during the placement.

It can be seen from Table 11 that Health Visitors are the main group that are used as clinical supervisors for the community placements. Only 6 colleges mentioned PCNs as supervisors, and in all these cases a Health Visitor was also mentioned.

TABLE 12. The Professional Groups Named as Clinical Supervisors for Community Experiences

	STARTED	NOT STARTED
TUTORS	9 (39%)	5 (42%)
HEALTH VISITORS	19 (83%)	5 (42%)
PCNs	6 (26%)	4 (33%)
SCHOOL NURSES	11 (48%)	1 (8%)
VARIOUS*	4 (17%)	2 (17%)
DISTRICT NURSE	1 (4%)	
MIDWIFE	1 (4%)	
NURSERY NURSE	1 (4%))	
TEACHERS (SPECIAL NEEDS)		1 (8%)

* This category is used where there are multiple short placements in for example, social service settings

The Assessors of the Practical Competence of the Students

Child Branch diplomates will be able to nurse sick children in the community and so the issue of who assesses their competence, and how this competence is assessed in this clinical area is of importance. This is because of the relatively independent nature of community practice. It would seem reasonable that assessment should be of competence to nurse **sick** children in community settings. It can be seen from the data that nearly 90% of colleges that have started the Child Branch use Health Visitors to assess

the practical competence of students in the community. Only 30% of colleges use PCNs. The other group that is relatively frequently used are School Nurses. Of course many colleges use more than one group to assess practical competence because of the broad range of community experiences that can be offered. In Table 12 we can see the cumulative frequency of use of certain combinations of groups. Starting from the top we can see the number of colleges using Health Visitors alone, then those using Health Visitors and School Nurses plus other groups, then those using the latter as well as PCNs and others.

TABLE 13. Groups Assessing the Practical Competence of Child Branch Students in the Community?

	STARTED	NOT STARTED
HEALTH VISITOR	20 (87%)	8 (67%)
SCHOOL NURSE	11 (48%)	3 (25%)
PCN	7 (30%)	6 (50%)
TUTOR	5 (22%)	3 (25%)
NO ASSESSMENT	4 (17%)	1 (8%)
NURSERY NURSE	3 (13%)	1 (8%)
VARIOUS	2 (9%)	1 (8%)
MIDWIFE	2 (9%)	0
DISTRICT NURSE	0	2 (17%)
RMNH/CPN	0	1 (8%)

TABLE 14. The Pattern of Assessment Groups*

	STARTED	NOT STARTED
HEALTH VISITOR ONLY	3	0
HEALTH VISITOR + PCN	7	6
HEALTH VISITOR + SCHOOL NURSE	10	3
HEALTH VISITOR + SCHOOL NURSE + PCN	5	2

* The discrepancy between the total number of Health Visitors and the total above is because of combinations such as Health Visitor and CPN, Health Visitor and Tutor etc.

From the above table we can see that the commonest pattern in the colleges that have started the Child Branch is that of Health Visitor plus School Nurse plus others. The commonest combination in those that have not started is Health Visitor with PCN.

Assessment And Mentorship Issues:

There is general acceptance among the teachers, students and mentors, interviewed up to present, that the Health Visitor is the best placed person to supervise and mentor the student in relation to their community experiences. Very few practitioners within community services either District Nurse, School Nurse or Health Visitor have the RSCN qualification. Students' and mentors' comments indicate that the students have only minimal contact with children who are ill within the community and community

experience therefore generally follows a health model. Children who are ill are primarily cared for by hospital based services normally with services being directly delivered from the hospital base. There are therefore perceived to be only minimal opportunities for the students undertaking the Child Health Branch to gain experience nursing children who are ill within the community.

> "... but interestingly enough when you go to meetings where health visitors are objecting and saying, you know, that students can't achieve this and its unrealistic and what have you, you don't hear many voices from the health visitors who're actually, you know sometimes people are reluctant to say well actually its worked fine. We do get some voices who say that, but they are not very loud" (Centre 1: Teacher).

Most centres used a profile or booklet to identify the learning outcomes which the student must achieve during their period of community experience. In the relatively short period which all centres studied allocated for community experience the assessors found this process difficult both in terms of identifying the areas for assessment and the level of ability which the student achieves. In terms of these difficulties of assessment in the community a teacher observed:

"We would give an example, they quite rightly said but

that's breaking down our job into tasks rather than the holistic aspects of it" (Centre 1: Teacher).

Other concerns surrounded the issue of supervision and support and the level of performance being observed:

> "Even if they can do it once they're doing usually means you're seeing them do it in a variety of novel situations and act appropriately and they can maybe only chart up seeing them do it once appropriately and didn't feel that they always say yes, I'm really confident that they could do it in most situations" (Centre 3: Mentor).

Making assessment decisions on very little evidence of practice due to the short placement time involved concerned many of the assessors. They felt they had a professional responsibility to ensure that the future practitioners were competent but were concerned at the understanding of the level which was being assessed.

From the interviews with teachers at one centre, there was evidence that assessment levels had been lowered within centres to meet the experience which the student was able to undertake. One centre which has revised the booklet explained,

> "... because really the booklet and the level of achievement were really quite high and the amount of input that the students were having to do in the

community when they have never been there before, was, it was just too much. Really you were expecting, it was the sort of thing that you were expecting of the student health visitor with all that background previously to do and the student wasn't up to that and also we didn't feel that was appropriate, and we just didn't have that time to do it" (Centre 1: Mentor).

Others saw that the level of the learning outcomes as a cause for concern. A mentor commented:

"I think that some of the outcomes that they were expected to achieve in the booklet was perhaps to some extent endangering our clients, we felt" (Centre 3: Mentor).

These remarks were reflected at other centres that learning outcomes were being lowered to meet the experience that was available rather than designing the experience to meet the expected learning outcomes.

In some centres interpretation of expected learning outcomes identified as an issue but one centre reported that:

"In order to try and perhaps keep it uniform we've got practical learning outcomes which all students will have and we've also got an assessment form which is the same across the board for all four branches but its open to interpretation for the individual branches and each student is expected to reach certain levels within the assessment scheme at certain stages of the course so those are the things that we try to draw and make uniform the experiences. Plus we run reflective practice sessions for the students plus we have a tri-partite system between the community mentor, the student and the teacher so again we're keeping up links and liaisons" (Centre 4: Teacher).

It would seem then that those centres that have tried to clarify the expected learning outcomes between all parties concerned have experienced less frustration within the assessment process.

The main problems in relation to the Health Visitor undertaking the assessment role are summarised by a student who explains assessment as:

"Mainly talking about what you do, they give you an insight into their job but obviously we're not training to be health visitors we're training to be paediatric nurses" (Centre 3: Student).

This type of comment was reflected within the centres where this model was in operation and gave rise to the impression that a low level of expectation existed in terms of the learning experiences provided. This feature was also reflected throughout all the centres in relation to the desired level of performance, rationalised by the amount of time the student spent within the community. The type of comment most prevalent was "what more can you expect within a short period of time?". This indicates strongly that the level of learning expected within community experience is relatively low to that expected within the hospital; and generally within the learning levels of exposure and participation or the low levels of identification within the Steineker and Bell (1979) Experiential Taxonomy. This generally compares with the expectation of achieving internalisation and dissemination within the hospital practice experiences. This phenomenon was further emphasised by all four centres studied as a summative assessment of practice within the community was not undertaken, although this was the case in the hospital placements. The explanation for this would seem to relate directly to the length of experience.

Mentorship also, not surprisingly, emerged as a major issue with regards to the quality of the learning experience which the student undertook.

"Some students get a very good deal with some Health Visitors ... it would be nice to identify these people but unfair to them to sort of keep sending students to them because they've got work to do as well and almost its penalising them for being so good" (Centre 1: Teacher).

Mentors were generally reported to be good and supportive and the students appreciated the pressure that some of the community practitioners were working with, especially those who were covering for colleagues who were sick or on maternity leave etc:

"The mentors are very dedicated in the community, they really took it seriously and gave us as many experiences as they could" (Centre 2: Student).

"She was absolutely brilliant. She just made it so much fun for me, we had like a really good working relationship" (Centre 3: Student).

Some students did report experiencing some unfortunate and unacceptable experiences:

"She had this list of things that 'piss me off' and she had written on this wall 'student nurses'. And this was the first thing I saw when I came in and I mean she actually pointed it out to me on the wall and I thought 'Oh my God!" (Centre 3: Student).

This is an extreme example but is representative of a feeling which was experienced by a number of students in two of the centres, that they were seen as 'pests' or as a source of 'nuisance'. This was usually associated with those community practitioners who had little motivation to have students allocated to them and it brings into question whether it is appropriate to allocate students to these practitioners. As with other professions it should be seen as a recognition of expertise and skills to be allocated those whom are learning the profession. Unfortunately, within nurse education the allocation of students is not viewed in this light and it may be that measures ought to be introduced which would provide this type of framework and alleviate the need for students to be experiencing unacceptable situations similar to that highlighted within this chapter.

There are particular problems associated with the Health Visitor undertaking the role of mentor because the student does not recognise them as a specific role model for paediatric nursing and this tends to dilute the dynamics which are an important aspect of mentorship. It may be that one mentor could be provided for the entire period of community experience who was a Children's Nurse and would regularly discuss the students' community experience with them but they would not have to provide all the community experience for the student. This other experience could be gained with the Health Visitor, District Nurse and School

Nurse etc. The study has identified a number of specific responses which suggest that these practitioners are not the most appropriate to be undertaking the roles of mentor or assessor, but they certainly could be making a contribution to these situations in a similar way to that which the ENB empowers other practitioners when it is relevant and appropriate due to the specific skills which the student is aiming to develop.

The Philosophy Underpinning the Course

There are several questions that arise from the consideration of the Child Branch programme that have relevance for this study. The first is the question of whether the philosophy considers the question of the nature of community in respect of P2000 programmes. It is almost a truism that there are as many definitions of community as there are studies of it (Bulmer 1987). However, for a programme of professional training it would seem a reasonable assumption that programmes, that are subject to some overall control in terms of content, have some standard of what constitutes an appropriate clinical placement in terms of that course's definition of community. The wide variety of placements used by colleges could be driven either by the demands of a philosophy or the pragmatics of finding placements.

The second is that the philosophy is able to distinguish

between the various roles that a diplomate of the programme will be called on to play. So, for example, it would seem reasonable that the philosophy in some way will represent the call on Paediatric Nurses to nurse sick children upon graduation.

Information was requested about the philosophy of the child branch. 31 philosophies were analyzed, 4 respondents did not provide a philosophy or provided one for another course. A content analysis was done on the replies (Holsti 1969) to identify any conceptualisation of 'community' and the possible role that the diplomate of the Child Branch would have within it. A central theme emerged with the majority of replies mentioning the importance of the family and the consideration that it should be given when considering the child's interests. The general term that encompasses this is "family centred nursing'.

Environments, Home and Community

Four main terms were used to express the idea of nursing children in settings other than hospital. The first was environment in the sense of, for example, children having "... the right to receive care within an appropriate environment" (College No.5). The second term was settings, so, for example, the nurse will be "... competent to plan, implement, and evaluate appropriate care for the sick child and family in all settings" (College 41). The third term used is community itself; a nurse who is "... a confident

and able practitioner in both the hospital and community setting" (College No.4). The fourth term is "home'; "... wherever possible the child should be nursed in his own home" College No.17). Three colleges did not use any of these terms, or any other that located the Child Branch in the community.

It can be seen then, that there is not a consensus in the use of the terminology related to the community, indeed whether such a term or a synonym for it, should be included in a course philosophy.

A central concept that emerged from the data analysis was the differing interpretations of the meaning of community or non-institutional experience used by the course teams on the Child Branch. Three of the centres studied identified non-institutional experience as both NHS Community Nursing and Health Visiting, and non NHS community experience included such areas as "... things like toddler groups, mum parent groups, parent stress organisations and that kind of thing" (Centre 2: Teacher). Within the Common Foundation Programme experiences within the wider community included areas such as leisure centres, sports centres, community centres and industrial work experiences. One centre had interpreted the non-institutional experiences as non-NHS "Community Nursing is seen as institutional" (Centre 1: Teacher). This view was clarified:

"I can see a value to that, in actually having that experience ... as opposed to going with the Health Visitor because I think its important that you see things from perspectives other than health profession perspectives so that's why they are in the community" (Centre 1: Teacher).

The ENB guidelines for the curriculum development of Branch Programmes have the expectation that 50% of the programme must be theory and 50% must be practice. Of this 50% practice component, 50% must be institutional experience and 50% must be non-institutional. The survey has already demonstrated that relatively few centres have managed to meet these requirements and the study indicates that it is the shortage of community nursing experiences for nursing children which is possibly the major factor in this.

It must be accepted that there are some limitations to the use of this data. The first is that there was an uneven response to the question. Some colleges submitted copies of their philosophy, others reported this in note form. This could be for a variety of reasons, an incomplete philosophy, perceived problems of confidentiality, and lack of immediate availability of the information. It could also be the case that the philosophy section of a course submission is seen more as a statement of conventionally required principles rather than an expression of the

underlying values and concepts of the course team. However, because of the disparity in terms used for community, and the differing expectations of the diplomate it seems reasonable to accept that this is not the case.

Meeting The Learning Outcomes And Competence To Practice As A Children's Nurse:

The learning outcomes which the students undertaking the Project 2000 course must achieve if they are to be able to register as a children's nurse are identified in Rule 18A of the Nurses, Midwives and Health Visitors Rules Approval Order 1989. The student must achieve the competencies associated with these learning outcomes in relation to the relevant sphere of practice, therefore in respect of the children's nurse, the student must demonstrate competence in all the learning outcomes to a level of safe practice with a child and family client group. A number of these leaning outcomes concern health activities and community issues for which it is reasonable to presume that the student would need to demonstrate competence within a period of community practice. It is the expectation of Project 2000 that the children's nurse would be competent to provide nursing care for a child and their family, in respect of their health and illness needs, and to be able to do so in either the hospital or the community setting. The guidelines which were issued by the ENB for the curriculum development of the Project 2000 course, and which were stated earlier, were formulated with this aim in view.

The main focus of the in-depth study was how the teachers, students and mentors felt that these objectives were being met and to identify some of their experiences since the implementation of Project 2000. The study particularly attempted to identify the levels of competence which the students felt they were developing and to compare this with the views of their mentors.

Some students viewed the outcomes of the course in the following ways:

> "I'd say we're being led to promote health rather than nursing illness" (Centre 1: Student).

> "I feel well prepared to look after children in hospital and promoting the health and the illness in hospital. Community wise, no I don't. I wouldn't like to go out as a newly qualified staff nurse and have the responsibility of looking after someone community wise" (Centre 4: Student).

At one centre it was reported that the learning outcomes set for the community experience had to be lowered due to their unrealistic nature for the period of community experience that was available. A student described this process in terms of:

"Many of the assessments weren't valid because they had to give exemptions for the criteria" (Centre 1: Students).

"We have outcomes for every one of our placement experiences. I mean, they are very simple, they're very superficial" (Centre 4: Student).

These comments all reinforce the view that the learning outcomes are being fitted to the experience that is available rather than those which are required by Project 2000 and those which the student must satisfy to be registered as a children's nurse. This is further emphasised by the following statement:

"If you look at the outcomes for the community placement they are very, very broad outcomes which do not mention sick children, they're very much child centred but they don't highlight sick children so they can achieve their learning outcomes on that 4 week placement by never seeing a sick child" (Centre 2: Teacher).

A mentor further explains the position in relation to the assessment of the learning outcomes stating that the Health Visitors were:

"Not assessing them in terms of being a competent practitioner within the community. You're assessing them that they have got some skills that are being developed" (Centre 1: Mentor).

The reality is that students who have completed the Project 2000 course are being appointed to posts within the community in the belief that they have been assessed and have achieved the desired learning outcomes. The end result of this situation is that there may well be nurses practising within the community who have undertaken the Project 2000 course who have not been appropriately assessed in relation to their competence to practice at a safe level. A Paediatric Community Nurse gave a comprehensive description of his area of concern:

"I'm not convinced that I've seen any curricula for any course which would allay my concerns that the outcome of training, a Project 2000 registrant, is able to assess, implement, and evaluate care in the community setting. I would be surprised if anybody was delivering a practitioner at the end of the course that was able to do that without immediacy of day to day supervision for a fairly long period of time" (Centre 4: Mentor).

From these concerns emerges the concept of competence. Exactly what level of competence is safe practice and what

type of practice is aimed for at the end of the course. Certainly within 3 years students are not going to be able to perform at the level of the Paediatric Community Nurse or the Health Visitor, but it was never realistically envisaged that they would:

> "I think they would need to build on specific skills, specific knowledge about the area that they work in, different area profiles, the epidemiology of the area, ... but that would come with experience and under supervision with a preceptor" (Centre 2: Mentor).

These are exactly the post registration conditions under which all new nurses are expected to commence their professional nursing practice.

> "Theoretically they should be able to (be a safe and competent practitioner within the community) because they've had a vast amount of theory in relationship to the first 18 months looking at the person in society and the rest. They've had experience of working within hospital with sick children and in the community with just healthy children. You could say that perhaps if they achieved Diploma level at the end of the three years and have reached the level of synthesis then to me they should actually be able to perhaps put those three things together on academic level" (Centre 2: Teacher).

They would become different practitioners to those whom have been developed in the past. They will still require support and supervision wherever they will practice whether that is the hospital or the community. They are entitled to undertake a period of preceptorship which will prepare them for primary practice.

The analysis of this category has revealed some serious problems with regards to a number of issues all of which relate to the expected learning outcomes and competence to practice. It appears that the learning outcomes set for students in relation to their periods of community experience are not consistent with those stated under the Rule 18A outcomes and therefore there must be serious concern in relation to the assessment of nurses' competence to practice especially in relation to community orientated learning outcomes. None of the centres within the study undertook a formal summative assessment of the students competence within the community and this was left to be undertaken in the hospital where it would be impossible to summatively assess all the Rule 18A learning outcomes. It would appear, that as with any major curriculum innovation, practitioners and teachers will change the learning outcomes to those with which they are familiar and those which fit their current arrangement for learning experiences. Project 2000 presented a challenge to nurse education if it was to be met creatively and the study appears to indicate that this challenge is not being

addressed in relation to children's nursing probably due to some of the extreme difficulties, especially in relation to community practice, that are being encountered.

The Links That Exist Between the Education and the Community Staff

All colleges that have started the Child Branch have Link Tutors with the community staff. The fact that only 66% of the colleges that have not started the Child Branch have link tutors is, perhaps, a reflection of the stage of development of the programmes rather than the development of a new model of clinical links.

TABLE 15. Links that Exist between Education and the Community

	STARTED	NOT STARTED
LINK NURSE TEACHER	23 (100%)	8 (66%)
COMMUNITY NURSE TEACHER	18 (78%)	7 (58%)
EDUCATION LIAISON COMMUNITY NURSES	6 (26%)	0
LECTURER PRACTITIONERS	1 (4%)	2 (17%)
JOINT APPOINTEES	1 (4%)	1 (8%)

The preparation of community practitioners for what are new responsibilities has been a recurring theme which may have had an adverse affect on the success of some community placements and led to some of the confusion which is

reported to exist. It may be that with greater experience that some of these initial problems are being overcome.

> "I think it was initially perhaps quite badly planned in as much that they didn't prepare the field staff in the appropriate way" (Centre 1: Mentor).

One centre reported working particularly hard, by the development of strong relationships with the Community Practitioners, to overcome the type of confusion which is described below:

> " I used to get calls from Health Visitors who were a bit confused initially ... they were not taking them (students) to various visits because they thought they have only to see health they can't see anybody unhealthy. It was quite odd but I think it is all sorted out now" (Centre 1: Teacher).

Reported Difficulties In Organising Placements

From Table 16 it can seen that 39% of colleges who have started the Child Branch report no problems in getting community placements. If we look at Table 17 below

TABLE 16 The Difficulties Colleges Have Had in Organising Placements

	STARTED	NOT STARTED
NONE	9 (39%)	0
GEOGRAPHICAL SPREAD	2 (9%)	2 (17%)
SHORTAGE OF PLACEMENTS	12 (52%)	5 (42%)
MANAGERIAL CHANGES IN THE NHS	2 (9%)	2 (17%)
HAVING TO PAY FOR PLACEMENTS	4 (17%)	1 (8%)
SMALL NUMBER OF PCN PLACEMENTS	2 (9%)	2 (17%)
AUDITING OF PLACEMENTS	1 (4%)	0
PROVISION OF LINK TUTORS	2 (9%)	0
SCHOOL HOLIDAYS	3 (13%)	0

we can see that half of the colleges using the PCN as the core experience do not have any problems in organising placements.

TABLE 17. The Child Branch Core Community Experience for Colleges Having No Difficulties in Obtaining Placements

CORE EXPERIENCE	NUMBER OF COLLEGES WITH NO PROBLEMS	
	STARTED	NOT STARTED
HEALTH VISITOR	3	1
PCN	3	
SPECIAL NEEDS	1	
UNDER NEGOTIATION	1	

The most frequently cited problem for both groups is the shortage of placements. This seems to be related to several factors. The first is the competition for places in community settings because of the sheer volume of students that require them on the Common Foundation Programme. The second is the reported withdrawal of some agencies because of the number of students. The third is because of changes in the NHS, the growth of trusts, GP fundholding and other related factors. which leads to increased difficulty in negotiating placements.

The Practitioner in the Community

15 out of the 31 responding colleges gave some indication of the sort of practitioner that their Child Branch programme was designed to produce in their philosophy. The general sense was of a practitioner able work in a variety of "settings', with a range of descriptors about the level at which they work. Table 17 gives the frequency of use of these descriptors.

It can be seen that, and taking into account that a substantial number of colleges had no identifiable terms, there is no consensual language used in philosophies relating to the competency of the diplomate of the Child Branch programme. Nor, in general, do the philosophies give a picture of the expectations of the diplomate in terms of their community role. It can be seen that at

least 5 of the colleges have a concept of an independent/autonomous/self-directed practitioner. 12 of the above colleges included one of the synonyms for non-hospital care in conjunction with the above terms. It must be assumed therefore that there is possibly a range of expectations in the colleges themselves about whether the Child Branch diplomate will be an independent practitioner working in community settings, or whether they will have a less defined role. The term 'competent' is interesting in this context, as in no case was there an attempt to deal with the issue of what constituted a competent practitioner working in community settings.

TABLE 18. The Capabilities of the Child Branch Diplomate

TERM USED FOR Diplomate	NUMBER OF COLLEGES USING THE TERM
AUTONOMOUS PRACTITIONER	2
INDEPENDENT "	2
COMPETENT "	5
SPECIALIST TRAINING	1
ACCOUNTABLE PRACTITIONER	1
ENHANCING HEALTH AND WELFARE	1
SELF-DIRECTED	1
PROVIDING EFFECTIVE CARE	1
CONFIDENT AND ABLE	1

The suitability of newly registered children's nurses to work within the community is viewed by practitioners and teachers as being unrealistic;

"Paediatric Community Nursing work tends to be very intensive ... I feel it would be very unrealistic to put a newly qualified member of staff into that sort of situation" (Centre 4: Teacher).

Students in three centres, although feeling some anxieties about the challenges presented by practising in the community, strongly supported the need for the sort of community nurse exemplified by:

"D grade staff Community Paediatric Nurses. I see no reason why you've got to be so far up the scale and so experienced to get into the community because its just as important to have good qualified nurses in the hospital as it is in the community" (Centre 3: Student).

A Paediatric Community Nurse provides an explanation of why they need to be so experienced:

"I think they need (newly qualified nurses) a lot more hospital training because a lot of the stuff we are teaching parents to do technical things, we only look after sick children within the community ... these things take a lot of experience and I feel you should have a broad background in paediatrics before you could even come into our jobs. I don't think its appropriate unless they've had further training

because it is a technical job, if not, I mean, part of it is advisory but you have to be, you know, clinically updated" (Centre 2: Mentor).

The Paediatric Community Nurses explanations of their role revealed that because of its broad nature they often did not possess the technical skills necessary to undertake specific nursing interventions. When faced with these situations they would arrange to visit a recognised specialist practitioner who would teach them the skills required which would then enable them to care for the child within the community and, if appropriate, teach the parents the skills to care for their own child. It is difficult to imagine that this approach to practice could not be replicated with a less experienced nurse but one whom was knowledgeable in terms of the possible needs of the child and their family.

The Nature of the Learning Experience

A theme which emerged, primarily, from the students and which appears relevant throughout the models of community experience was the inconsistency of learning experiences. Wide variations were identified in respect of the depth and quality of these experiences. This was a major cause of concern for many students who felt that with the opportunity for experience being so limited they had, in some sense, been deprived of significant learning experiences. One student stated:

"I've had my first week and I've actually only been out on about three visits to different children and the rest of the time I spent in the office, just because it wasn't particularly busy at that time and she had a lot of paperwork to do" (Centre 2: Mentor).

Another student described their community experience as:

"I only ended up getting 4 visits in my 4 week experience. I don't think I got anything much out of my community experience with the Health Visitor" (Centre 3: Student).

This can be compared to the experience of another student who had the experience of visiting,

".... a number of families, about four to five different children a day for five days a week so that was, what, ten days, so it approximately fifty children" (Centre 4: Student).

Although these two examples emphasise the disparities that can exist within one sort of community experience the students in all centres felt strongly that some kind of minimum learning experiences should be guaranteed for them, although they recognised that this is difficult to achieve

given the nature of community nursing. A mentor identified some of the issues which are involved and which can affect the quality of the student experience:

> "We can't guarantee what things they are going to be on and what they are going to see because it depends on the workload and how many of us are working and things" (Centre 3: Mentor).

Some students also identified that another factor that affected the quality of their community experience was the locality in which they undertook their experience. They reported that they could miss out on valuable learning experiences and although they did share experiences between themselves it could not compensate for not having the experience available for them. Teachers also agreed with this, "It is fair to say that in some areas there are less opportunities" (Centre 4: Teacher). Another teacher explained how they have tried to overcome this problem;

> "Well, we've tried to align them so that at every point in the practice placement students are doing very similar things, but I think it will depend on whether they are placed in a rural area or whether they are placed in a town area" (Centre 2: Teacher).

There also appears to be conflicting practices in relation to this issue of locality, with some centres believing that

it is best to base the students' community experience in one area so that they can gain a deep understanding of both the overt and covert factors which are present. They appear to believe that the community experience present micro-experience of community nursing issues which can only be reorganised at a deep and pervasive level if the student has been able to develop a deep relationship with the area. Other centres believed that it is better to provide the students with a macro-experience of community nursing as that will enable them to recognise the variations and differences of practice present in different communities. However, given the data from the survey, it could be argued that in general the student community experience will be too short to achieve this.

The analysis of the models of community experience demonstrates that the two main models discussed are at the opposing ends of the continuum of practice with the child and family. Neither model represents the preferred model of practice for the future paediatric nurse and yet both models have much to contribute to the development of the 'new' practitioner. The analysis suggests that both models are integral components of the desired learning experiences for the children's nurse and a more comprehensive model of practice should be developed which includes the full spectrum of practice.

It can be concluded under this category that at present students are getting very different experiences within the community and this depends on a number of factors which are difficult to manipulate effectively given the numbers of community practitioners which are available for facilitating experience. What the students appear to be asking for is some minimum learning experiences which could be guaranteed from whatever experience they undertake and which would guide their experience. This would at least create some feelings of equity of experience which is not being experienced at present.

Another significant issue to emerge is that it would appear not to be a question of which model of community experience is most preferable, but more one of recognising the merits of each and looking at how these could be incorporated in to a more comprehensive community nursing experience for students on the Child Branch.

Transferring Hospital Experience To Community

A category which emerged with uniform strength from the teachers, mentors and students was that it was not only possible, but desirable to transfer experience from the hospital to the community. The hospital was seen as the base from which the student would learn all their basic skills and experience with caring for ill children. It was then seen as being appropriate for the practitioner to develop their practice into the community from this 'broad base'.

"I personally do feel that the students need some more hospital gained experience of working with sick children within a hospital setting, seeing more children, dealing there and then moving these skills into the community rather than, I mean, I know the idea might be at the end of training they can move straight in to the community" (Centre 1: Teacher).

A student explains the situation from their perspective:

"You are heavily reliant upon the experience you get in the hospital, you've been able to utilise that to assist you in the community" (Centre 4: Student).

The hospital was strongly felt to be where the newly qualified practitioner would consolidate their skills in relation to caring for children. This concept is heavily reinforced by the practices of the Paediatric Community Nurses, few of whom are presently prepared through a community based course and who are generally self-selected from very experienced hospital children's nurses who decide to extend their practice into the community.

Some practitioners recognise that this process of transferring skills may not be as simple as some others appear to view it:

"Some of the students would say that their primary base for learning about nursing sick children is within the hospital. Is that transferable into the community or

are there more major needs that the students would have to be able to apply that within the community setting" (Centre 3: Mentor).

This theme was later on in the interview further developed:

"I think within the community setting they're not only, (hesitation)... there'll not just looking after the sick child. Now they'll be some arguments from hospital to say that they are not either but I think it's more specific in the community because you're dealing with one household and you have to perceive what needs are within the household as well as what the needs of the sick child are, bearing in mind they've also got parents and carers to think about" (Centre 3: Mentor).

This issue may well centre around whether nursing is being delivered from a client and family centred needs model or if it is being delivered from a task orientated model. The task orientated base focuses on the task to be undertaken and the technical and practical skills which are required to undertake it. The client and family centred model focuses on the wider needs of the individuals and the context in which they are being cared for. Within this model the technical and practical skills are seen as something which can be gained from others who possess these skills; but the contextual skills, the higher order skills, which assess the wider needs of the individuals should be

developed through the exploration of specific fields of knowledge and through experience with skilled practitioners who work within the context.

This issue may well be the result of being subjected to a simple process of conceptual thinking which does not adequately represent the complexities of reality. It may be appropriate and desirable for teachers, students and mentors to examine more deeply their thinking on this issue and to reconsider the original intentions of Project 2000 to enable them to reassess the realities of this situation.

One practitioner when interviewed and asked if he thought students were able to transfer the experience, knowledge and skills which they learned within the hospital into the community setting, had the view that:

> "Well, yes of course you transfer it. If you've learned principles you can transfer the same principles into the community, but the slant is different, what you're meeting is completely different" (Centre 4: Mentor).

This response also begs the question as to what principles the student would have learned within the hospital which are important in respect of community especially relating to the higher order skills of assessment. The students may also be hanging onto the context which is most familiar to them, the hospital, and rationalising the complexities

of practising in the community because the expectation causes them dissonance.

As a final word in this section a Health Visitor explained her view on this issue and illuminates some of the complex psychological issues which are affecting rational thinking:

> 'I think that the person who has done the Child Branch would be best employed by working in hospital for two, three or four years or whatever and then if she feels she wants to come into the community then do the extended training of health visiting and come out as a health visitor with a much wider remit for the whole health of all age groups within the community.'
>
> (Centre 1: Mentor)

Professional Concerns:

A number of serious professional concerns were raised by respondents. Many were associated with the assessment process, the numbers of students, detrimental effects on relationships with clients of students being present, role confusion and fears over the new practitioners which would be developed as a result of Project 2000. The one which mentors raised with the most regularity and strength of comment was the possible detrimental effect of relationships with clients. Comments ranged from:

"Sometimes it isn't appropriate to take a student into a household. It does affect your relationships with the parents definitely" (Centre 2: Mentor).

to:

"Delicate situations exist that she doesn't feel she can take the student into" (Centre 3: Mentor).

Another mentor explained:

"A lot of them feel that sometimes it intimidates the families who don't gain their confidence initially if they keep the students with them" (Centre 1: mentor).

This situation directly affects the student opportunities for experience. One student explained:

"I was working with a Health Visitor who sort of chose what houses you went into, chose which ones' were appropriate and I only ended up getting four visits in my four weeks experience. I don't think I got much out of my community experience with the health visitor" (Centre 3: Student).

Some other students in two centres were also frustrated by this situation, which could seriously affect the quality of their community experiences. One student stated when asked what they did when the practitioner was undertaking a visit

and did not wish to be accompanied said, "... Sat in the car, sat in the Health Centre" (Centre 3: Student).

The comments of the students indicate this is not an uncommon occurrence and although it must continue to be the right of the practitioner to make a decision on the suitability of having the student in attendance, this should surely be only in extreme situations or when the client themselves indicate that it is not acceptable. Interestingly, this latter explanation was never stated, within the interviews, as the reason why a student could not accompany the practitioner.

On a more optimistic note a mentor described how they approached this situation:

> "There will be times when you may well have to say to a student they can't go on that visit for personal reasons, confidentiality reasons, in which case they would leave the student in with a colleague or give them some work to undertake which would enhance their knowledge of the Health Visitor role for the student" (Centre 3: Mentor).

Students and practitioner also identified fear of the new practitioner as an issue which affected the students community experience. It was still inconceivable for many community nurses and health Visitors to believe that the students should be competent to nurse children within the

community. Due to this 'mind set' the level at which students are exposed to experience is at a level which is inconsistent with the learning outcomes of Project 2000. This appears to set up a situation where 'the law of prophecy' will apply, students will only receive the experience which community practitioners enable them to experience. There would appear to be clear evidence that some of this is due to the threat which the student presents to the future of community practice and the present practitioners.

A professional concern which is consistent across all the respondents was the one of the numbers of students and the effect which this has on the length and quality of community experiences. Experiences had been organised not due to the desired learning needs as emphasised by one mentor:

> "Principally though not because of their learning needs but because of our capacity as a service to actually accommodate them" (Centre 4: Mentor).

The number of students is having an effect on the community practitioners. A student stated:

> "I think I was more a sort of pest to her, she had so many students that she really didn't want anybody with her. That came over right from the beginning" (Centre 3: Student).

A mentor explained her strong commitment to students and nurse education but explained:

> "They felt very strongly that they would like to take students along there and provide them with a longer experience but the limitations imposed by the volume of students to be got through and I think that a mistake was made by the college and they recognised that in taking too big a set of students" (Centre 4: Mentor).

This comment emphasises the central issue that the number of students must reflect the ability of the service to provide the learning experiences that are required to facilitate developing competence in order to meet the desired learning outcomes. The mechanisms that are used to decide the appropriate amount of students within the community can be called into question as emphasised by one nurse teachers' comments:

> "So the argument about numbers of students coming out, and what have you, I don't know. I don't feel, it doesn't appear to me, yes they have other students from other courses which is fair enough. I can appreciate that but I think this idea of pressure of numbers of students, I feel its a bit of a myth. That's my personal opinion because if you work it out you know, a health Visitor will, if they are lucky, will get a student once a year for a month" (Centre 1: Teacher).

Data collected from other centres indicate their requirements may well present community practitioners with students for longer periods but the point remains that there is, at present, no accepted mechanism for identifying how often a community practitioner should have a student allocated to them. It would appear to be helpful if this type of information was made available and mechanisms developed which accurately identify the numbers of students which can be offered experience within a designated service to ensure that the desired learning outcomes are met.

DISCUSSION

In the literature review we saw that there were two central ideas that emerged about the role of the paediatric nurse in the community. The first was that they should be highly skilled, the second was that they should be sensitive to the needs of sick children and their families. From the results of the survey and the interview data it is apparent that several things are happening in teaching the student to fulfil these needs.

The first is that the main role models and generally, the longest and most frequent placements for Child Branch students in the community are with Health Visitors. There is evidence that these placements vary considerably in their quality of experience and that they emphasise the healthy rather than the sick child. The second is that the main supervisors and assessors of Child Branch students in the community are also Health Visitors.

However, the picture is confused by the relatively small number of colleges that use paediatric community nurses as the core community experience, and by those colleges that use a variety of other community placements. The differences in the location of the placements is further complicated by the wide range in the length of both the core placements and also the length of the total experience.

The reasons for this disparity seem to lie in two areas: the first is the pragmatics of organising placements. Community paediatric nurses are thin on the ground and the demand for placements is high. The second lies in some confusion about what a community placement means: there is little consensus about what the community 'is' in terms of paediatric nursing. The emphasis on health seems to lead to a reduced emphasis on the technical skills necessary to deal with sick children in the community.

From the interviews with the students and the survey data Community experiences within the Common Foundation Programme were rarely focused on the child and their family for those who wish to undertake the Child Branch. The concept of Common Foundation Programme' is still possible without disregarding the area of practice the student ultimately wants to undertake. Comments within the study indicate the serious implications of a generalist approach in Common Foundation Programme to the students ability to learn about children and their families. The difficulty of what the new programme aims to achieve is emphasised by a teacher who remarks:

> "I honestly thought that what they would come out with is what I had to work four and a half years for and I really don't know that you can put four and a half years into three and expect you know" (C3: Teacher).

The reality is that more expectations are made than in the past for the new practitioners and so,presumably, to enable

the desired practitioners, to develop the focus for learning needs to be stronger.

Many of the respondents agreed that the community experience must be longer and more comprehensive. No one particular model of community experience meets the comprehensive needs of the student in relation to both health and illness. The data implies that there was generally agreement that the students should have experience across a wide range of community practitioner including the Health Visitor, the District Nurse, the School Nurse, the Paediatric Community Nurse and the Outreach Clinical Paediatric Clinical Specialist Nurses.

However the present community experience seems to be associated with just widening awareness of the community rather than skill development. Perhaps if the period of community experience was lengthened it should be focused strongly towards the development of technical and practical skills. Community practitioners need to be clearer about the relevant skills that they are attempting to assist the student to develop and should move away from just enabling the student to observe the role which they undertake. The learning experiences must be strongly focused on skill development and the student should undertake experiences with the practitioners who possess the skills that are relevant to their expected learning outcomes. It was apparent from the needs assessment that the level of skills

required of the community nurse is of a high order and it was difficult, when looking at the type and length of placements for students, to see how, in most cases, these skills could be developed.

It would seem especially important to make effective use of the PCNs. Outreach Paediatric Clinical Nurse Specialists, recognised as being particularly skilled, presently seem to offer learning experiences in an opportunistic manner because of the pressure for placements. It would be desirable for all Child Branch students to be able to undertake a period of experience with a Paediatric Community Nurse although this would present problems for some centres who would wish to offer courses. It is for them to decide how they could arrange this experience but the study suggests all courses should offer a comprehensive experience of community nursing for the student and this can not be achieved without a period of experience with children who are ill, supervised by a skilled practitioner. This obviously has implications about the future validation of Child Branch programmes where a reasonable amount of such placements cannot be given.

The experience of managing a small community case load is seen as being an important learning experience by students although it presents community practitioners with some professional concerns. It is inevitable that if this desired experience is to be made available to students that their period of community experience will have to increase

to prepare students and mentors to confidently approach this experience.

The implication of these points is that due consideration should be given to the pragmatics of placement organisation when courses are validated. We have shown that there is a considerable disparity nationally in the range and quality of placements. Given the high level of skills required to work in the community with sick children, the very range of experiences would seem to indicate that there will be a wide range in the skills of diplomates from different programmes.

The Preferred Model For Preparing Nurses For Caring For Children In The Community:

A preferred model emerged from the study which is characterised by the following features:

1. It provides a comprehensive model of community experience and includes learning experiences within NHS Services, Non Statutory Agencies, Schools, Nurses and other wider community organisations. Experiences provided are focused towards caring for children.

2. The comprehensive community experience includes significant periods of experience learning the

skills of those practitioners who possess the skills which it is desired for the student to acquire. The student is not placed with only one practitioner as one practitioner does not posses all the skills which they need to acquire.

3. It has a list of minimum learning experiences which can be guaranteed for every course participant.

4. The learning outcomes for the community experience are drawn from the learning outcomes stated for Project 2000.

5. Mentorship is provided by a nurse who is recognised as a paediatric nurse even if they are not specifically employed for that role.

6. It provides a significant experience of community nursing experience of a minimum of 12 weeks (3 months) duration. This period is still short of the ENB guide-lines of 19 weeks but is probably more realistic to attempt to accommodate.

7. The Common Foundation Programme enables students who are aiming to undertake the Child Branch focus their studies on the child and family from an early stage. This does not prevent them

receiving a 'common' experience, nor does it prevent them from undertaking experience in the other branches of nursing where the focus is just as relevant.

8. The Common Foundation Programme must have regular teaching input from Child Health Nurse Teachers and the Children's Nursing Focus must be strengthened.

9. The Branch should have a period of rostered community practice where the student realistically undertakes the role of the Community Practitioner and is summatively assessed with regarding their competence to practice at a safe level.

This model will inevitably mean that the number of courses that are validated is reduced. However, this seems reasonable if, as seems the case at the moment, there is no common currency in the diplomates being produced from existing programmes.

Limitations of the study

The area that we considered in this project is vast, ranging from the phenomenology of consumers of nursing care

to the organisation of educational programmes. In a one year project methodological decisions will be made that have implications for the generalisability of the results of the study. Many of these issues have already been discussed in the Methodology section of this report. They revolve around the nature of case study material and the nature of the inductions that can be made from them. It can be argued that because of the issue of sampling error then conclusions cannot be drawn from case studies and especially so with limited case studies.

This argument has some force especially when the study consists solely of case study material and the typicality of the cases is difficult to establish on theoretical grounds. In the case of this study we would be inclined to argue that its central feature is the survey and that the material in the in-depth interviews and the needs analysis has been used to clarify issues that have arisen from the very nature of survey data. Maximum variance purposive samples were used to bring into focus the central issues that arose from the literature search and from the survey. The issue, then, is one of the theoretical appropriateness of the sampling frames that were used for these, rather than the issues of indeterminate sampling error.

The nature of the non-responders in the survey is an issue that needs addressing. As a population survey rather than a sample survey was undertaken the characteristics of the

non-responders could be regarded as important because they introduce an element of indeterminacy into the measurement error. However, practically, a calculation using the worst possible scenario, that all the non responders, for example, give a community experience that is required by the P2000 requirements, still means that the median community experience in the Child Branch is still well below that required. The survey figures should, therefore, be regarded as the pessimistic picture. However, the data from the four centre interviews selected on the maximum variance principle would give support for the notion that this pessimism is theoretical rather than actual.

Conclusion

There is a very wide range in both the length, the nature and the quality of the community experiences that Child Branch students get. The skills needed to work in the community with sick children are of the highest order. In this study we hope that we have managed to clarify these issues and to suggest some ways forward. As we pointed out in the introduction, the health service and health professionals are living in rapidly changing times: perhaps this disparity in experiences and training is something that needs to follow this path.

RECOMMENDATIONS

We recommend that:

1 In the validation of courses careful consideration should be given to the degree of correlation between the number of students and the community experiences available.

2 Further examination should be made of the impact that current changes are having in the NHS and the implications of these for the diplomates of the Child Branch.

3 Further consideration should be given to the role of the Health Visitor as supervisor, assessor and major source of placements for the Child Branch students.

4 Further examination of the nature of the diplomate of the programme be undertaken in the light of the current reforms and consequent changes in the NHS.

5 Further consideration be given to the possible role of the Child Branch diplomate in the community setting.

6 There should be an examination of the possible support that the newly qualified children's nurse will need to have in the community and how this could be provided in the current situation of the NHS.

7 Further research be undertaken to further clarify the roles and skills of the various professional groups working in the community, and how these relate to the Child Branch diplomates' role and skills.

8 The nature of the Common Foundation Programme and its relationship to the Child Branch be considered in terms of the relevance of the experiences in the Common Foundation Programme with those of the Child Branch.

9 The definition of community that is used in P2000 programmes is clarified.

10 Steps are taken to clarify what the community based skills for Child Branch diplomates should be, and how these skills relate to current skills of diplomates.

11 All programmes contain material on how to establishing health care needs in community settings.

12 Steps be taken to ensure that learning outcomes are related to Rule 18A of the 1979 Nurses and Midwives and Health Visitor Rules Approval Order and not substantially driven by community exigencies.

13 The assignment of students to people in the community should be driven by skills and not the exigencies of obtaining placements.

14 The professional validation of Child Branch programmes should be based on the education centre's ability to provide a community placement for students which guarantees minimum learning experiences.

15 The community experience should be a balanced programme in terms of both the maintenance of health and providing care for children who are ill.

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APPENDIX 1 CONSENT FORM.

In signing this document, I am giving my consent to be interviewed a nurse researcher. I understand that I will be part of a research study that will focus on the preparation of nurses to care for children in the community. This study is funded by the English National Board for Nursing, Midwifery and Health Visiting.

I understand that I will be asked some questions about my experiences as a parent in relation to the nursing care which my child has received. I also understand that the interviewer may ask some questions to my older children during at least some portion of the interview. The interview will take about one hour to complete.

This interview was granted freely. I have been informed that the interview is entirely voluntary, and that even after the interview begins I can refuse to answer any specific questions and can decide to terminate the interview at any point. I have been told that my answers to questions will not be given to anyone else and no reports of this study will ever identify me in any way. I have also been informed that my participation/non-participation will have no effect on the services that I or any member of my family will receive.

This study will help nurse educationalists to develop about a better understanding of the needs of parents and children in relationship to nurses' training. I understand that if I have any questions about this study or about my rights as a study participant I can contact Keith Cash (Centre for Health Studies, University College, Salford, 736-6541 ext 414).

Date Respondent's Signature

Interviewer

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APPENDIX 2

QUESTIONNAIRE:

The Preparation of Nurses to Care for Sick Children in the Community

boxes for office use only

Would you please answer the following questions. (For some of these questions it should be possible to enclose relevant documentation rather than a written answer).

1. Which pre-registration children's nursing courses are offered from your centre?

Project 2000 ☐

RGN/RSCN ☐

Other (Please specify) ☐

2. Which post-registration courses for children's nurses are offered from your centre?

Course	No. of Students

boxes for office use only

3. For each children's nursing course could you state how long it has been offered.

Course	Length of time offered

4. What philosophy underpins each of your courses? (If the philosophy is described in any documentation, would you please enclose it for each of the courses that you offer)

5. What non-institutional placements do your Children's Branch students have?

boxes for office use only

6. What are the expected learning outcomes for students in non-institutional placements?

7. Could you give details of the timetable for student non-institutional placements.

   a) Common Foundation Programme

   b) Child Branch

8. What are the arrangements for the clinical supervision of students within placements in non-institutional settings?

boxes for office use only

9. Who assesses the practical competence of the students on their community experience (for example health visitors, community paediatric nurses etc.)

10. What experience of community paediatric care does your children's branch programme education staff have (e.g. health visiting, district nursing etc.)?

11. What are the community nursing services in existence for the care of sick children in your area?
Please circle as many letters/numbers that apply.

A. community paediatric nursing service.
B. district nursing.
C. health visiting.
D. specialist paediatric nurses.
   1. Macmillan nurses
   2. Oncology nurses
   3. Cystic Fibrosis
   4. Urology
   5. Haematology
   6. Diabetic
E. other - please specify

boxes for office use only

12. Are there any formal links between the education and the community nursing staff?
Please tick the appropriate one(s).

A. link nurse teachers
B. community nurse teachers
C. education liaison community nurses
D. lecturer practitioners
E. joint appointees
F. other - please specify

13. What difficulties have you had in organising non-institutional placements?

THE FOLLOWING QUESTIONS REFER TO THE COMMON FOUNDATION PROGRAMME

14. What specific areas of knowledge, attitudes and skills are identified for development within periods of community experience?

boxes for office use only

15. What community experience do the students on the common foundation programme have?

16. What proportion of this community experience directly relates to caring for children?

APPENDIX 3

23 June 1993

Dear

Re: ENB Research Project:
The Preparation of Sick Children's Nurses to Work in the Community

We have been commissioned by the ENB to research into the preparation of sick children's nurses to work in the community. This is a P2000 evaluation project and the research project has several parts.

- The first part is a survey of all the colleges of nursing providing a children's branch of P2000.
- The second part is a series of focused interviews comparing educational experiences in areas that have community paediatric teams and those that do not.
- The third part is a needs assessment based in one centre. It is hoped that the results will enable an informed decision to be made about the preparation of sick children's nurses to work in the community.

We are writing to ask for your co-operation in providing information for the first, (the survey) part of the study. Any information you give is completely confidential and in the final report no College will be identified. The information required is related to the curriculum, the structure of the children's course, and the sorts of community experience that students have.

It would be of great help to us if you would provide us with permission to contact your senior tutor of the Children's Branch. We enclose a form in which you can write down the relevant information along with a pre-paid envelope, we would be most grateful if you could send the information to us by 12 July 1993.

Yours sincerely

Dr Keith Cash
Senior Lecturer in Nursing Development
University College Salford

Mr Peter McAndrew
Head of Dept Branch Programmes
Bolton and Salford College of Midwifery and Nursing

Enc.

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Yours sincerely

Dr Keith Cash
Senior Lecturer in Nursing Development
University College Salford

Mr Peter McAndrew
Head of Dept Branch Programmes
Bolton and Salford College of Midwifery and Nursing

Enc.

APPENDIX 4

20 July 1993

Dear

Re: ENB Research
The Preparation of Sick Children's Nurses to work in the community.

The Principal of your college has given us permission to contact you about the above project. The project examines the sort of preparation that Sick Children's Nurses have to work in the community and to make recommendations about that preparation.

Some of the questions could best be answered by enclosing the relevant documentation rather than a written answer. All replies and documents will be treated in confidence and will only be made available to the Research Team.

Thank you for your co-operation in completing this questionnaire. If you need any further information please do not hesitate to contact us.

Yours sincerely

Dr Keith Cash
Senior Lecturer
Nursing Development
University College Salford

Mr Peter McAndrew
Head of Dept Branch
Programmes
Bolton and Salford College
of Midwifery and Nursing

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